

# **Learning to Recover. Patients' accounts of their post-surgery experiences**

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### **Abstract**

This is a qualitative study the main purpose of which was to explore female surgical patients' descriptions of what for them, constituted the experience of 'recovering'. A second order aim was to find out what might have helped or hindered post-surgical recovery. The sample consisted of 9 patients from an elective orthopaedic unit (Ward A) within a specialist orthopaedic hospital and another 9 patients from a vascular ward (Ward B) within a large general hospital. The participants were aged between 30 and 80 years. Taped semi-structured interviews were conducted pre-operatively in hospital and post-discharge in the participants' homes. Narrative analysis of the unedited transcriptions of these interviews identified common meanings and themes. Comparisons were made between the first and second interviews and between the two ward groups. Interpretation of the emergent themes was done using the sociocultural learning theory of Lave and Wenger (1991). The employment of this theory enabled 'recovering' to be conceptualised as a learning process. Distinctive differences between the two patient groups related to the presence or absence of positive portrayals of the recovery experience as a 'shared travail' in Wards A and B respectively. The communal portrayal of recovery from the Ward A participants was discerned in their reflective and theorising narratives which frequently were diachronically structured evoking very 'visible' day-by-day remobilisation routines. The importance of routines in aiding the peripheral participation of patients in the practice of recovering was explored. In the Ward B presentations of recovering, a much less 'visible' patient work was identified which appeared to relate to the lengthy and event-driven character of peripheral vascular disease. Common to both sets of accounts were presentations of self-responsibility. These presentations were interpreted as concerned with legitimacy and membership within the complexity of relations involved in recuperative practice. It was suggested that these relations included 'rule-following' and 'rule-hunting' activity. 'Glimpsed' within the accounts of both participant groups, was the place health professionals, in particular nurses, may have had in the relations of context that made up recovery practice.



### **Declaration of originality**

This thesis was composed entirely by myself. The work reported herein was conducted exclusively by myself in the Department of Nursing Studies at the University of Edinburgh.

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*In memory of my father Bob Grant 1/7/22 – 11/6/96.*

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### **Notation for transcribed interviews**

- R - respondent/participant
- FM - investigator
- ( ) - small portion of taped transcription indecipherable on playback
- (( )) - containing paralinguistic details
- [ . - when interviewer and interviewee talk simultaneously
- bold** - for particular attention

## *Chapter 1*

# **Introduction**

### **Part 1**

In this study surgical patients' recovery experiences as they saw them were sought. Hill's (1978) definition of rehabilitation assisted in the initial conceptualisation of this research because a distinction was made between establishing capacity, a medical remit, and the 'teaching-learning' process of utilising capacity which involved an 'expressive' component to recovering. It was this teaching-learning process that was sought within the study participants' portrayals of their recovery experience. 'Recovering' for this research was viewed as experiences upon a continuum of patient activity involved in healing. In keeping with this perspective 'recovery', 'rehabilitation', 'recuperation' or 'convalescence' are terms which are used interchangeably.

The experiences of eighteen women who underwent surgery were garnered from one-to-one interviews. These interviews took place in hospital the evening before surgery and then in the participant's home post-operatively. According to Forrest et al (1985), 'having surgery' is part of a process of some illness experiences as well as an event which in itself causes what could be termed a 'therapeutic injury'. This definition was illustrated by the profiles of these eighteen women nine of whom were admitted to an orthopaedic ward for hip or knee surgery and the other nine to a peripheral vascular unit for arterial or venous surgery. Apart from the surgery of the latter group of participants being linked with an on-going chronic illness and all the difficulties associated with this, the participants from both groups to a greater or lesser extent experienced the consequences and complications of the 'therapeutic injury'.

The experiences of the participants were looked for in the narratives produced within the accounts of recovery. Whenever people are asked about health or illness their answers are not just about their physical condition but are accounts which seek to construct a place for themselves in the everyday social world of relationships and responsibilities (Radley and Billig 1996; Backett 1992). The participants' accounts about



their recovery from illness to some sort of healthier state were expected to yield a complex set of ideas that reflected the social discourses of the society in which they interacted. Bruner (1991, p5), described narratives as not only representing but 'constituting' reality. By this he meant that culture could be accessed through narrative in that 'cultural products' such as language mediate thought and so colour representations of reality. From the perspective that narrative is 'an instrument of mind in the construction of reality' (Bruner 1991, p6) some sense of the 'reality' of recovery as a social and cultural experience was hoped for.

As a process which involves change, 'recovery' was conceptualised as a learning experience. 'Learning to recover' has been a neglected area of study. The reason for this situation is that there has been a paucity of research in patient education which has sought to address the patient's experience of learning. This situation is illustrated in the patient education literature in the field of nursing. The perspectives taken within the nursing literature have been concerned with teaching patients rather than with the nature of patients' learning. As a consequence, any learning that has been studied has tended to relate to knowledge gained from particular teaching initiatives orchestrated by professionals. Such an approach has focused upon some end point of learning achievement and has not attended to the process involved. The latter, the practical 'doing' of recovery was investigated in this work.

Concomitant with the emphasis upon teaching, research has tended to focus upon a professionally identified knowledge concerned with information and skills to equip the patient **for** a recovery experience and not to the experiential knowledge **of** recovering. The approach taken in this study has been to seek out the latter within the accounts of patients' recovery experiences on the premise that most of what can be known about recovery resides within the 'doing' experiences of those who are recovering. According to Engestrom (in Lave 1993) there is a major gap in contemporary learning theory because there is a failure to address how 'new knowledge in practice' is learnt. The emphasis in nursing upon professionally identified recovery knowledge and the transmission of this knowledge seems to reflect this theory deficit. On reflection, the emphasis upon the transmission of existing knowledge influenced one of the original objectives of the research which was to find out what surgical patients had to say about the educational interventions they had received from health professionals. However, in

seeking a research design which was contextually sensitive, an educational frame to the questions asked of the study participants was not adopted. Only in the exploration and interpretation of the themes which emerged from the accounts which the participants gave of their experiences was an educational theory taken up. Lave and Wenger's (1991) sociocultural learning theory was adopted to further develop these themes.

Elicited in the examination and comparison of the participants' accounts was the presence of the other ward patients. The health professionals who were referred to in these accounts were placed within a wider shared context of activity rather than engaged in one-to-one teaching-learning activities with patients. A major characteristic of the accounts was the participants' social contextualisation of their experiences of recovering. This consisted of placing themselves and others within the activity of recovering which was shared by way of the ever-changing social relations within the practice setting. This activity was seen as extending into the interview contexts in the form of representations of self-responsibility by the study participants. In Lave and Wenger's (1991) theory of situated learning the way in which people change and develop is through participating in ongoing activity within a socially constructed world. Context, from this theoretical perspective, is integral to learning. Learning, according to Lave and Wenger, is conceptualised as a process of increasing participation in 'communities of practice' from a position of peripheral activity towards one of increasing participation and membership.

At this juncture is appropriate to make clear the meaning of 'participation' that was adopted in this work. This is necessary given the frequent and different use of the term in health care literature. In this literature 'participation' is referred to in the context of defining the patient as a consumer of health care (Lupton et al 1991). The rationale for patient participation is founded upon the ideological view that those who are directly affected by the decision-making processes related to care should have a part in these processes (Brownlea 1987). Greater patient participation is equated with greater patient involvement in the decision-making concerned with care. It may be an invited participation and/or one that is facilitated through the design and exploitation of the organisational structures and 'social properties' respectively within the care-setting (Brownlea 1987; Davis 1980, p40). Lupton et al (1991) argued that the whole case for this approach assumes that the patient is willing and/or able to take on an empowered role (Lupton et al 1991). It can be argued that this conceptualisation of 'patient participation'

is 'owned' as it were, by the health professionals. In this formulation the activity of patient participation happens because the professionals have decided that it should. From Lave and Wenger's (1991) perspective, 'doing' the recovering or learning to recover is about beginning as a junior participant or member on the outer environs of the complex matrix of social and cultural relationships that are involved in a 'community of practice', and moving towards fuller participation in such a community. Such relations of 'doing' amongst a community of patients practising recovery would include those with professionals but the resultant changes in practice would not be in a predictable or professionally predetermined form (Wenger 1990). With respect to this learning theory, relations of practice with professionals are part of a greater complexity which makes up the social context of the 'doing'.

In this study in the exploration of the patterns of similarity and difference within and between the narratives from the two participant groups, participation and membership were found to be pivotal. Something of the social and cultural context of 'recovering' within the two wards and beyond was identified. In particular, the concept of 'patient work' (Strauss et al 1985) emerged as pertinent in the interpretation of contrasts. Through working with this conceptualisation of the participants' recovery portrayals in conjunction with Lave and Wenger's learning theory the complexity of the surgical patient's experience was revealed. A direct consequence of this were fruitful insights into the position of nurses and other health professionals within the patients' learning experiences.

## **Part 2**

In this part the structure and main features of this thesis will be described.

The literature review (Chapter 2) begins with an examination of the values and perspectives of the health professionals and of the wider society. This examination looks at the contextual pertinence of these values and perspectives in colouring the social and cultural experience of recovery. This is done by addressing the ideas and associated professional accounts which are part of what could be described as the 'healing context'. The powerful influences of individualism and biomedicine are identified. There follows a study of the literature which relates to the nature of recovery knowledge. The theoretical, applied and practice forms of recovery knowledge are explored in relation the individual's experience of differing expectations within the hospital and other care

contexts, as well as those of the wider society, as to what 'recovery' is and how it should be achieved. The principles of sociocultural learning theory (Lave and Wenger 1991) were drawn from the educational literature and used to underpin a critical review of the literature that relates to the participative relations of the recovery context. A short review of the literary works which were informative as to the patient's experience in hospital is included because of the relative lack of research sources concerning this experience. Finally the literature which relates to the role of the nurse in patient learning is examined and interpreted from Lave and Wenger's (1991) sociocultural learning perspective.

Chapter 3 consists of an epistemology and a description of the research methods undertaken. Within the former the use of interviews is discussed. The characteristics of narrative are explored in relation to the objectives of the research. The narrative analysis is elaborated upon and a resume of the data interpretation is given. Issues of validity based upon the 'trustworthiness' rather than the 'truth' of the interpretations made are discussed. It is pointed out that although there were great efforts made to make visible the situated nature of the interviews and the accounts that were generated, the researcher was aware that what could be 'discovered' would provide only a 'glimpse' at the 'reality' of the recovery experiences. On the other hand, because of the contrastive nature of this study, there was much in the differences of form and content within the interview narratives which provoked more questions about the recovery experience. Further, the differences elicited, generated the adoption of an educational theory hitherto unused in the study of recovery, and this led to further ideas and questions concerning the recovery experience. The description of the methods undertaken relates in particular to: the patient sample and the sampling context; approaching patients; carrying out and transcribing of the interviews and the processes of analysis and interpretation.

In Chapter 4 the unedited interview transcripts are examined. According to Gilbert and Mulkay (1983 in Silverman 1993) 'the goal of the analyst ..becomes that of reflecting upon the patterned character of participants' portrayals of action'. Patterns to the participants' portrayals of their recovery experience are identified and the reflective process begins. Patterns such as self-responsibility; communality; rule-following and rule-hunting as portrayals of experience are discussed.

In Chapter 5 the process of analysing the portrayals of experience identified within the participants' accounts in the previous chapter is taken further. The reflective and theorising activities that these portrayals contain are examined in relation to what they may reveal about the nature of 'recovery' as a learning experience. Lave and Wenger's (1991) sociocultural learning theory is an integral part of this analysis. As a consequence, how recovery experiences are contextualised or framed by the participants is addressed so as to ensure a focus upon the learning processes involved. Representations of responsibility are examined and related to the need for learner legitimacy. The context of learning is considered as it corresponds with accounts in which learning experiences are framed or unframed by rules and routines. Finally, the therapeutic narrative (Early, 1982) within the accounts is analysed with the aim of identifying what was learnt through the 'doing' practice of recovering.

In Chapter 6 the analysis is taken onto a more abstract level. The areas of this analysis relate to the structures and the complexity of relations for participation in learning that were 'glimpsed' in the participants' accounts. Recovery learning is related to the 'patient worker' perspective and ideas about the shared quality of experience and knowledge. The relative 'visibility' and 'invisibility' of the two sorts of surgical recoveries is considered in terms of the learning experience. The concept of the heterogeneity of experience is explored as it relates to the positive and negative portrayals of social relations of recovering in hospital. This exploration is linked to the accounts of less 'successful' recoveries. The role of clinical institutions, nurses and other health professionals in patients' learning is addressed.

Chapter 7 is the conclusion of this thesis. It consists of a summary of the work and a consideration of its contribution to knowledge. The possibilities for the generation of future research are explored.

## *Chapter 2*

# **Literature review**

That this review is divided into six parts perhaps reflects the breadth and complexity of the task of researching the recovering, learning experience of the patient. In the first part, the literature concerned with the professional and societal context in which recovering is experienced will be examined. Part 2 is a review of literature which explores the nature of recovery knowledge and Part 3 follows with an examination of a sociocultural learning theory which is utilised later to interpret the findings of this study. In Part 4 this educational theory is used to underpin a critical review of the literature that relates to the participative relations of the recovery context. A review of literary sources which can inform as to the patient's experience in hospital follows (Part 5). The literature which relates to the role of the nurse in patient learning is examined and interpreted from a sociocultural learning perspective (Part 6) and finally a summary is provided (Part 7).

### **Part 1: The 'healing context', social and cultural perspectives within the professional literature.**

In exploring what constituted the experience of recovery for surgical patients through the collection of patients' accounts of their experiences, it was expected that what was said would reflect something of the 'worldview' or ideology used to interpret such a 'reality'. According to the folklorist Dègh (1995), the 'concretizing element' within a narrative informs as to the character of the ideology. This element by its very nature of illustrating and persuading from the teller's 'real' life, could perhaps give this researcher access to some part of the social and cultural context in which surgical patients experience recovery. Farmer and Good (1991) described 'culture' as inherent in all social and psychological processes and therefore at the very root of all human experience and action. According to Wuthnow (1984, p126) the activity of speaking in itself can be seen as the performance of a ritual which affirms and reproduces the basic social relations and shared values of the speaker's social world. Further, it was hoped that the assumptions that interviewees make



as to the researcher's knowledge of the values and expectations of their sociocultural world could also prove insightful as to the nature of their recovering experiences (Bourdieu 1990). It was expected that the experience of recovering would be accessible through the narrative in accounts because language as a 'cultural product' mediates thought (Bruner 1991) and so something of the 'reality' of recovering was likely to be communicated.

Approaching the context of recovery or healing from social and cultural perspectives is not seen as at the cost of excluding or differentiating out the physical nature of the experience. However there has been little research which addresses recovery experiences as an amalgam of the physical, social and cultural (Kleinman 1992). Fitzpatrick (1983, p501) investigating the social dimensions of medical care upon the therapeutic outcomes for headache sufferers, argued that there was an asymmetry in medical science in not addressing the 'so-called placebo effect' as an area for serious study in the pursuit of effective therapies. Moerman (1997) argued that the 'placebo effect' is an area of important study concerning the relationship between healing or recovery from an illness and the symbolic nature of medical care. He suggested that the form as well as the general and specific content of medical care should be investigated. These issues, the researcher suggests, means that how the participants talk and what they talk about of the 'local world' of relationships, transactions, actions, events, that impinge upon their experience may provide a recognizable shape of the kind of local world experienced in particular recovering contexts in hospital and at home (Kleinman 1992). Moerman (1997) cites from Brody's thesis (1977, pp102-103):

'If being a dweller within culture is a special way of being an animal, it should not be anomalous if this characteristic were found to influence other animal capacities-including the capacities to undergo change in bodily status and function. Experiencing symptom change due to the placebo effect is therefore the bodily expression of the person's participation in the healing context as a culturally determined symbolic phenomenon.'

In this section the sorts of ideas and associated professional accounts which are part of what could be described as the 'healing context' will be examined.

Individualism and collectivism have been described as the two main ideological currents in Western societies. Both ideologies developed in the change from a medieval to

a modern society. Collectivist ideas were aimed at mutual aid in the face of growing capitalism and the concomitant exploitation whilst individualist ideas described the individual as the 'basic unit of society' and evolved from the social changes of the Reformation, Renaissance and the Enlightenment (Williams 1989). Individualism, according to Williams (1993) dominates Western culture and its influence could be found within narrative to do with health and illness. In his study of rheumatoid arthritis sufferers, for example, the individualistic conception of ill-health as something the sufferer is in some way morally responsible for, could be identified in the stoicism represented by the R.A. sufferers. Blaxter and Pearson (1982) found similar moral accounts amongst Scottish women who portrayed giving in to illness as behaviour upon which one could be judged severely.

Most social science research related to health has been concerned with the experiences of ill-health as opposed to health (Beattie, Jones and Sidell 1992). In addition, the ill-health experience that has been studied tended to be about long term and chronic conditions. Bury (1991) distinguished two sorts of 'meaning' in chronic illness. One he associated with the early stages of the illness and was to do with the everyday consequences and the other was to do with the illness's social and cultural significance in terms of symbolic imagery. The latter 'meaning' has particular significance in relation to this study in the case of the participants undergoing surgery concerned with the chronic illness, peripheral vascular disease (P.V.D.). Bury (1991) reviewed the work which explores how different illnesses have particular social connotations and how much the sufferer may seek to disclose or hide the effects of illness may be dependent upon the anticipated reception from others in their social context. Some illnesses are stereotyped such as epilepsy and can have a very negative effect upon self-identity. Visibility of symptoms which in a milder form are experienced by everyone (coughing in chronic obstructive airways disease - from Williams 1989) may not provide the social legitimacy or recognition that sufferers may seek, in fact the sufferer may be judged as 'undeserving' of sympathy and understanding if the illness is considered to be self-induced. According to Williams (1990) those with C.O.A.D. suffer in silence. Another respiratory condition, genetically acquired and therefore with 'no blame' status, -cystic fibrosis- is viewed very differently by society with sympathetic media coverage and supportive public interest. It



seems that the individualistic ideology of a moral accountability for one's own health may open or close the door on the potential support within the person's social world.

Individualism dominates the medical profession's approach to health and illness. (Friedson 1970 cited by Williams 1989) Evidence of the powerful influence of the biomedical interpretation of health/ill-health can be traced in the pervasive 'healthy lifestyles' discourse propagated through the media and government supported institutions (Beattie et al 1992). An underlying assumption of such discourse is that there is individual choice as to how one conducts one's life. The practice of medicine has developed a scientific 'cosmology' (Jewson 1992) in which the illness has been conceptualised as a biochemical process which has to be analysed and explained in terms of cell pathology. According to Jewson the production of medical knowledge has shifted focus from the prognosis and treatment of the patient to this emphasis upon finding answers in the laboratory. Medicine's perception of the sick man has changed through history from a holistic view of the 'person' in which the emotional and spiritual were as essential to a diagnosis as the physical, to the present day object oriented framing of the patient as a 'cell complex' (Jewson 1992,p47). With such an orientation, recovery is a physical process explained in a scientific and rational manner. As a consequence, it is perhaps not surprising that when recovery does not progress well, it is likely to be explained in terms of non-compliance with medical advice. A good deal of the professional literature pertaining to recovery, has been concerned with compliance or rather non-compliance (Playle and Keeley 1998). Compliance has been defined as: 'The extent to which the patient's behaviour (in terms of taking medications, following diets or executing other lifestyle changes) coincided with medical or health care advice' (Haynes et al 1979 in Conrad 1985)

Playle and Keeley (1998) described compliance as an ideology based upon professional beliefs as to the 'proper' roles of patients and professionals. Looking at why patients do not comply seems to have been the main area of interest to researchers. Two approaches have been taken to investigating variations in compliance and non-compliance. These approaches have involved a conceptualisation of non-compliance as either a problem of poor communication within the doctor-patient relationship or that the patient's health beliefs are in some way inappropriate. According to Conrad (1985), the problem with these sorts of investigative rationales has been that they were doctor-centred. In his study

of medicine-taking in the everyday lives of epileptics, he argued that rather than looking at why patients don't conform to medical advice, researchers should address more closely what it is that **is** being done. He argued that 'non-compliant' epileptic sufferers were seeking greater self-regulation within their illness experience by way of their medication-taking activities. Activities such as testing out the ongoing need for the prescribed drug or working out a 'practical practice' of medication-taking which suited the 'social environment' of individual epileptics were taking place amongst the study participants.

It could be argued that both medical perspectives concerned with compliance result from the dominant individualistic ideology within medicine. Apart from biasing research findings of professionals, this ideology may have detrimental effects upon recovering experiences. In his case study of a self-help group, the National Ankylosing Spondylosis (A.S.) Society, Williams (1989) identified how individualism was the dominant ideology at work in the activities of the self help group preventing the A.S. members from benefiting from the collective, mutual aid potential of such a group. Unlike other forms of arthritis, A.S. treatment regimen involves daily exercises which seem to ameliorate its symptoms. Williams argued that the medical conception of A.S. as a relatively benign illness if the sufferer adhered to this regimen, imposed a responsibility not experienced by others with different forms of arthritis. Due to a heavy presence of doctors in the Society's organisation, self-reliance was promoted. Letters sent to the Society which sought mutuality and reciprocity of some kind were in the main, not published or were firmly reframed to relate to the medical conception of A.S. rehabilitation as being about self-reliance, motivation, self-discipline and compliance with medical advice. Within such a framework of meaning the sufferer could be blamed for an unsuccessful rehabilitation. William's observations highlight the condition specific nature of the social reception chronically ill people may experience as well as the dominant position of individualism in recovery 'texts'.

Hill(1978) noted that there were differences in the care staff's approach to patients in two different units of chronically sick people: renal dialysis and physical rehabilitation. She argued that a 'value incongruity' existed between the staff and patients of the latter due to each holding different theories of illness causation. Both sets of patients held fatalistic and religious theories as to the cause of their illnesses. However, a more

positive staff approach to the rehabilitation of the renal patients was due to a medical 'no blame' view of renal disease, a view that may also be attached to most orthopaedic conditions. In contrast, the majority of medical staff viewed the physical rehabilitation patients as in some way, to blame for their disability. Condition-specific illness was not only in itself the source of moral judgement as Hill noted that there were further social and cultural assessments made on the basis, for example, of perceived links between specific illnesses and race and gender. It was argued that such findings made it essential that any study or practice of rehabilitation must take cognisance of a social and cultural level of analysis. Hill made clear that the acute medical model as the dominant ideology of care in the two units was inadequate, if not damaging to the process of recovery because it only attended to the first, more instrumental phase of rehabilitation- the establishment of capacity. The second more expressive phase of rehabilitation, a teaching-learning process of utilising capacity was neglected. Peripheral vascular disease has an aetiology strongly related to smoking so it could be conjectured that the socio-cultural context of recovering from P.V.D. related surgery may harbour behaviours of blame and guilt. 'Accounting for' the events in one's convalescence may elicit traces of this context.

Bury (1991), reviewing the sociological literature concerned with chronic illness, noted that there can be difficulties of social legitimacy in the long term after the initial onset of the illness. He cited the work of Kelly(1989) and MacDonald (1988) which identified the problems ostomy patients had in gaining recognition from doctors of the difficulties they encountered with stoma management after 'successful surgery'. Bury (1991) suggests that people with long term illnesses may experience 'crisis of credibility' in their social world when they complain of difficulties, especially after having treatments, when the perception may be that they have had their share of attention. 'Successful' operations may result in the patient being denied the social support he or she may actually need to deal with sometimes greater problems than they had prior to medical care. In P.V.D. it could be mooted that the surgical event results in a similar crisis for sufferers. The professional literature fails to explore recovery. The focus amongst the care professionals concerned with PVD has been upon the prevention of further deterioration of the condition and this in the main, has taken the form of foot self-care. The virtual absence of professional attention to their patients' recovering experiences may suggest that the

recovery of post-surgical patients may be fraught with problems of social legitimacy. How much the healing process may be affected by this could only be conjectured. However, that there is a relationship between biomedical discourse and social legitimacy seems to be borne out by a recent survey. Broom and Woodward (1996) found that when doctors took their patients' chronic fatigue syndrome symptoms seriously or 'medicalised' them, this conferred a social legitimacy. A legitimacy which enabled the sufferer to gain some sense of well-being and help and support through his/her relationships with others.

Further threads of individualistic discourse may be found in the professional literature which focuses upon 'patient participation' and/or 'empowering' the patient (Brearley 1990). The ideological assumptions of such a discourse is that there are one-to-one relationships between professionals and patients and that the former enables the latter to be involved in decisions as to treatment and care. In an area of care in which there has been much written concerning patient participation-gerontology-there is doubt as to whether such patient/professional relationships have become a reality (Jewel 1993). In addition, it could be argued that there are many contexts in which patients may not want opportunities for real participation in their care (Ingelfinger 1980). Reed (1991), in a critique of the Roper, Logan and Tierney (R.L.T.) model of nursing, suggested that one of the main reasons that there was a lack of 'fit' between the model and the real situation of patients was the focus upon patient 'independence' as the basis of care assessment and planning. Such an emphasis can, in circumstances in which the patient's difficulties with activities of everyday living are not solvable, place an inappropriate pressure to achieve a level of physical function. Research in different care sectors has identified that the patient's concern is not so much about their physical performance but to do with their ability to fulfill role expectations and maintain their pre-illness social position. (Reed 1991; Robinson 1993). According to Reed (1991), dependence as a positive concept is not addressed in nursing. Individualised nursing care, the 'sacred cow of nursing', has had the effect of focusing all rationales for care at the level of the individual. As a consequence the communal part of the patient's experience has been ignored (Reed 1992).

Opie (1997), examining the representational practices of health professional interdisciplinary teams found that a 'needs related discourse' dominated the interactions between professionals discussing individual patients. By this was meant that the talk was

most frequently to do with what the carers could do for the patient. That there may be therapeutic characteristics within a shared recovery context has not been explored in general nursing as it has to some extent in therapeutic psychiatric settings. (Sharp 1975). Reed (1992), mooted that the institution of particular ward routines may facilitate such contexts. The professional facilitation of collectiveness amongst patients through routines is an interesting concept. Of specific interest to this study is what form(s) of collective recovery might be revealed through patients' accounts. That some kind of knowledge sharing is experienced by patients in hospital, was described in Roth's (1963), participant study of hospitalised tuberculosis patients. According to Roth through observation of and interaction with other T.B. sufferers, patients accumulate a group-produced knowledge of the timing of different aspects of their treatment. Knowledge was built up as to the clues of physical progress such as having 'up time'. The T.B. patients imposed a recovery classification system to interpret their recovering position and progress, which was separate from the one operated by the institution.

In summary, it has been noted in this review that the professional literature to do with recovery tends to reflect the powerful influence of individualism and biomedicine. The values and perspectives of the professionals and of the wider society are of course, very pertinent as a context which colours the social and cultural experience of recovery. What is absent from the literature is how patients individually or perhaps collectively, experience recovery. Something of such activity may be glimpsed within patients' accounts.

## **Part 2: Recovery knowledge**

One way of exploring the patient's experience of recovery individually and collectively would be to conceptualise the experience as involving some sort of learning. The question of what it is that is learnt that could be termed a 'recovery knowledge' entails looking at the sort of learning it involves and the kind of knowing that is achieved. To explore these issues, how 'recovery knowledge' has been addressed in the literature will be related to theories concerned with the nature of practical knowledge. (Carr 1981; Bourdieu 1990). Carr (1981) distinguished between practical and theoretical knowledge, arguing that the former, the knowing 'how', was to do with reasoning about what to do whilst the latter, was concerned with 'the way things stand in the work' (Carr 1981 p55). Practical knowledge was to do with the 'mastery of practices' which was to do with getting to grips

with the rules of an activity and not of understanding theoretical principles. An analogy with recovery as a learning experience will serve to elucidate these ideas further:

A patient who has been recovering from illness goes to his doctor. The doctor tells the man that all is going well with his condition as his most recent blood results are back to normal. The patient however, wants to know how he will know that he is really on the mend, given that the previous week he felt he had had a setback and had spent most of the last few days in bed.

Theoretical knowledge about recovery, such as the attainment of a particular biomedical profile, is seen to bear little or no relation to the recovering experience of the patient. It contributes little to assist him with the vagaries of the process of recovery. What would relate to the 'doing' of recovering would be knowledge of **how** to go about the activity of recovering. Carr (1981 p60) contrasts the two forms of knowledge:

'The main difference between theoretical and practical knowledge, then, is that whereas the concern of the former is with the discovery of truths that are adequately supported by reason and confirmed by experience, the latter is concerned with the execution of purposes in action, conducted in a rational manner and confirmed by a reasonable degree of success.'

Practical knowledge according to Carr (1981 p60), means that one can know well how to go about a particular activity, but lack the physical ability to carry it out satisfactorily. Practical knowledge is made up of 'rules of practice' and the rules are the 'relations between prescriptions' and mastery of these rules, results in an understanding of an activity. This description suggests that to learn how to do something practical such as recovering from surgery, is about working through the procedural aspects of an activity and learning how they relate to a successful outcome.

Bourdieu's (1990 p82) argument in his treatise 'The Logic of Practice', that it is impossible to give 'a scientific account of practice' would appear to be critical of Carr's thesis. According to Bourdieu such accounts present a 'totalization' of the activity. By this he meant that the whole activity has been given boundaries of start and finish and is described as consisting of a set of relations linking one part of it to another that could be diagrammatically illustrated. He was critical of such descriptions of the relations within



social organisations, questioning the neat categorization of roles and relations amongst people. Totalization, Bourdieu argued, is a 'synoptic' view of practice which ignores the nature of practice as happening over time. Any analysis of practice has to overcome its temporal character, but in so doing, the true and full nature of practice is missed. Bourdieu's work highlights the limitations of 'how to' knowledge' in that no description of an activity can possibly include the infinite permutations of 'doing' which must happen in some sort of context. Although limited, this form of knowledge does contribute what Carr called 'rational procedures' which provide a framework for doing. How much of a contribution must depend upon how context dependent the doing is.

'Doing' as another form of knowledge which can be distinguished from 'knowing that' and 'knowing how', could perhaps be explored in relation to the nature of skill. In particular Holding's (1981) description of a spectrum of learned skills as existing between two continua is of interest concerning the context of doing. According to Holding, the nature of a particular skill could be identified by finding its place between simple-complex and open-closed axes. Of most note here is the latter continuum. Holding argued that in open skills, perception plays a dominant role and as a consequence, they are more dependent upon 'external stimuli'. Closed skills in contrast, tend to be motor or action dominated with little reliance placed upon external events. Examples from the recovering experiences of patients of relatively open and closed skills could be: organising rest for oneself after leaving hospital or correctly using elbow crutches respectively. Context is integral to an activity such as getting a restful convalescence for oneself. Communicating one's need for rest; juggling household and work responsibilities; tolerating being dependent; thinking of the specific advice given by a physiotherapist, are all possible facets to such 'doing'.

It would be impossible to pin down exactly the nature of 'doing' knowledge as context is always changing. Every 'doing' is interdependent upon a social context which can never be replicated. This is because the relations and the expectations within a context are always fluid and subject to change. As a consequence, knowledge of practice is inherently 'fuzzy' (Bourdieu 1990). That context also includes theoretical ('what') and technical (how) knowledge possessed by a recovering patient, but as Bourdieu notes, it is only in the

activity that one comes to know what to apply of one's knowledge of it. The knowing comes 'in action, in the relationship with a situation' (Bourdieu 1990 pp90-91).

In light of this, recovery knowledge, as it relates to the experiences of recovering surgical patients, must consist of all three sorts of knowing. A study of the literature uncovered, in the main, theoretical and technical knowledge to do with recovering. Given the intangibility of practice knowledge, it is perhaps not surprising that this sort of knowing is not fully represented in the literature. Attempts to glean its nature through research which seeks out the 'doer's' or patient's view of the recovery practice experience are hampered because a 'theorization' of doing, of practice knowledge, by the research participant, serves only to lose its essential nature. (Bourdieu 1990, p91). However, the researcher suggests that something of the character of such practice may be gleaned from work in which it is evident that there are presuppositions being made by the research participant of the investigator's knowledge of what is being talked about. A relationship which facilitates the 'language of familiarity' is most likely to reveal 'doing' recovery.

'This language which recognises only particular cases and details of practice interest or anecdotal curiosity, which always use the proper names of people and places, which minimizes the vague generalities and adhoc explanations for strangers leaves unsaid all that goes without saying' (Bourdieu 1990 p91).

The researcher suggests that something of practice knowledge may also be uncovered in a lateral way from less related literature because presupposition of knowledge to do with recovery may reveal a little of the actual 'doing'. The following literature review will look at what has been written which focuses or some way touches upon the recovery knowledge experience and how it relates specifically to post-surgical patients and to the ways in which they can be helped to recover. The literature can be broadly divided into two sorts. One with a focus upon knowledge **for** recovery and the other knowledge **of** recovery. The former being work which is oriented towards investigating patient education interventions and patient learning on the basis that there exists some sort of a priori knowledge which if learnt, enables the recovering process. The latter is research which aims to seek out the nature of doing the work of recuperation and is oriented towards knowledge of recovery as a process, a lived through experience.



The greatest proportion of patient education literature is centred upon knowledge for recovery. Patient education literature tends to be concentrated upon particular professionally prioritised skills to be learnt by patients for their continued recovery at home. For example, a search of the literature related to education and peripheral vascular patients found that there was an overwhelming emphasis upon teaching PVD patients foot care management. Another example of a skill well represented in the literature is that of managing self-medication. Such skills are very important for the continued and successful recovery of the patient, as well as for the prevention of further ill-health. However, apart from not addressing the kind of knowledge concerned with the 'doing' process of recovery, this focus upon a relatively discrete number of self-care skills is an overly narrow perspective upon the theoretical and applied knowledge for recovery that patients may or may not acquire when in hospital. Olszewski and Jones (1998), from their review of patient information literature, argued that 'professional' research has concentrated upon the delivery of knowledge and not upon the experiences of the patient. Reed (1991) was critical of the conceptualisation in nursing of the attainment of 'self-care' as definitive of health arguing that it only assisted in overall general value setting and did not 'inform practice'. Practice settings are inhabited by patients who may not be able to achieve these skills or do not share that conceptualisation of health and recovery. A good illustration of the relative dearth of attention in the literature to the 'how to' recovering of patients, is getting mobile. It is to be expected that some attention to this topic is given in relation to patients recovering from orthopaedic surgery who need fairly precise rules of remobilization, but equally, most convalescing surgical patients require some information and possibly technical skills to do with safe levels of mobility. In Baker's (1989) study of post-cholecystectomy, discharged patients, the participants were identified as having a high level of 'incisional awareness' and of reporting the need to 'rest a lot' due to fatigue. However, the professional advice to these participants concerning 'cues' as to safe levels of mobility was limited and lacked clarity. Why there is such a narrow range of skills for recovery dealt with in the professional literature may reflect the lack of professional knowledge about recovery (Wilson-Barnett 1988 (a); Baker 1989). A further conjecture is that both research and the lack of professional knowledge are to do with the acute care ideology which dominates health care delivery (Hill 1978; Latimer 1997). A care context

which is heavily influenced by acute medical priorities is less likely to be oriented to longer term recuperative issues. From a trawl of relevant databases, it is the researcher's view that recovery knowledge topics which are taken up by health professionals tend to be directly related to the specialist work carried out by doctors. In some situations of recovery, given Jewson's (1993) argument that historically, Western medicine has become an 'applied science' detached from the uncertainties of the illness experience, the recovery knowledge utilised and promulgated by health professionals, may be even more narrowly based.

In a study of patient perspectives on diabetes care and education based upon interviews with fifty-five insulin-dependent diabetics with at least five years experience of the illness, questions were asked about care and education received by these study participants at their four times a year visits to the diabetes out-patient clinic. (Wikblad 1991). The kind of professional input related to care and education experienced by the participants was found to hinge on their metabolic control evinced from blood results. Participants with good control reported receiving 'positive feedback' from the staff but no education or 'deep communication'. Information was not spontaneously given and professional responses to questions were viewed as unsatisfactory by the study participants because they were not always applicable to 'daily self-care'. Those participants with acceptable results received spontaneous information and education but again it was viewed as less than satisfactory as it was usually only 'technical'. The situation reported by those participants who had 'unsatisfactory' or 'unacceptable' control, was of poor relations and poor communication between themselves and the health care team. Of particular note was that patients said that they would lie about their actions as they had previously experienced negativity from professionals if they were honest. Often, particularly with those with the poorest results, there was no communication. When there was, it was perceived as compulsion, punishing and unsupportive. The 'educational' focus for those patients was upon techniques but without any rationale as to their usefulness.

Several issues are raised by such findings. Firstly, the nature of the recovery knowledge made accessible to patients was more likely to be of a 'how to' kind. At the same time such 'technical' knowledge was not seen by patients as sufficient to meet their everyday needs. Wikblad's study participants, on being asked what knowledge they

thought the diabetic patient needs to have, to manage everyday self-care, said that 'basic knowledge' of how the body reacts to insulin deficiency. Theoretical knowledge was necessary, according to these participants, and it had to be comprehensible and 'applicable' to the living experience of diabetes.

"By my own experiences I discover how my body reacts in different situations. No one else can tell me how I should live. I have to find it out by myself, but in doing so I need basic knowledge of diabetes" (participant response in Wikblad 1991 p840)

These relatively 'expert' diabetics did not want the theory applied for them but to have enough of it for them to do the applying themselves. This finding relates well to the idea that all three kinds of knowledge to do with recovery are inextricably linked (Bourdieu 1990).

Another issue raised was the variation in patients' access to recovery knowledge. This variation may be a key to why there is little knowledge of recovery as a learning experience. How a need for learning is established or otherwise, could be explored. From Wikblad's work those patients who had the best and poorest metabolic results received the least in educational terms. In view of the dominance of the acute medical model which places great value upon the veracity of scientific detachment, the problem centred approach to the assessment of learning need is likely to have difficulties. Those patients defined as problem-free on the basis of blood results would not be seen as in need of more learning. The issue of access to knowledge may also be clouded by stereotyping and value-judging activity found in health professionals' behaviour towards 'undeserving' patients (Jones et al 1997; Jeffrey 1979; Stockwell 1972). This would explain the situation of poor communication and information-giving experienced by the poor control diabetics. In a survey of patients and nursing staff from general medical and psychiatric wards which compared perception of physical and emotional needs and which included items such as receiving information and concerns over discharge, nurses did not know their patients at an individual level and operated with stereotypes in relation to patient needs (Farrell 1991). There may be difficulty in developing a comprehensive body of knowledge for recovery practice because the ideologies and practices of health professionals may get in the way of recognising or valuing its existence.

There has been research which has specifically compared health professionals' and patients' perceptions of learning needs. It is to be noted that Olszewski and Jones (1998) pointed out the difficulties of asking patients about their information needs. Given the influence of medicine upon the 'commonsense' theories of the lay public, they argued that getting at what is really relevant to the patients is a difficult problem. Two levels of ignorance are posited:

'First, when you do not know what you do not know and second, when you say what it is that you do not know' (Olszewski and Jones 1998 p9 quoting Jones 1997)

In a study aimed at establishing what role nurses' had in patient education, Tilley (1987) found that patients and nurses disagreed as to how much teaching was needed. Patients from cardiac and general medical wards thought that nurses taught enough whilst nurses thought they didn't teach enough. From a comparison of nurse and patient responses it was found that nurses underestimated the level of knowledge that patients had about their condition. Lauer et al (1982) found a similar incongruence between cancer patients and nurses. In that study nurses tended to overestimate their patients' needs for information about their treatment. The greatest discrepancy between the views of the patients and the nurses was to do with 'dealing with feelings' which was seen by nurses as the most difficult area for patients. The patients on the other hand, ranked it as the least problematic. In Casey et al 's (1983) study which involved patients and staff ranking in importance, the items included in a post-M.I. education programme, there was similarity and difference between professionals and patients. Of particular interest in this study was that patients were also asked to rate their knowledge in each of the areas ranked as most important to learn about. What came from this was that degree of knowledge did not necessarily relate well to perceived need to learn. For example, although the patients knew quite a lot already about 'coping with stress' they wanted to know more. Whilst they admitted to knowing little about how heart attacks happen, they ranked their need to know low.

Keeping in mind the conceptual and interpretative difficulties of research focused upon identifying need, (Olszewski and Jones (1998), some exploration of the incongruences and contradictions in the findings of such studies will be done. Chan (1990) taking her finding, which had corroborated earlier work, that recovering cardiac

patients rated very low the importance of learning about physical activity, suggested that patients may not want to know more about general levels of this but rather specific instructions, such as when they can drive again. A low ranking for learning about the reasons or explanations for events may be to do with an unfamiliarity with the theoretical, the anatomy and physiology, resulting in less interest in such information. Chan speculated that a low ranking by her cardiac patients, of 'psychological factors' which again was corroborated work (except for Casey et al (1984), may have been to do with a reluctance to deal with difficult feelings. In addition, although patients may see a need to manage their feelings, they may not necessarily see it as a learning need.

In a small study, Hiromoto (1991) evaluated the use of learning contracts with patients by developing a learning needs assessment tool in which the patients were first asked 'What do you need to know?' The tool was designed to elicit specific levels of interest in learning and a protocol of supplying particular learning materials according to level of interest expressed by the patient. The content of the assessment tool was based on Orem's self-care model. Applying this model meant the lower the interest elicited the less learning materials were made available to the patient. The assumption made was that patients always know what they need to learn.

Chan (1990) found that post M.I. patients were more likely to rate important learning areas as realistic to tackle after discharge home than while still in hospital. She argued that the timing of educational input was very important and recommended follow-up educational services to reinforce and build on what had been taught in hospital. Hiromoto's participants were outpatients at an oncology clinic. It may be that the assumption that they knew what they needed to learn was a valid one. Tilley (1987) had found that in relation to knowledge content, patients only wanted information that was immediately relevant to them. According to Chan (1990) as hospital stays get shorter, in-hospital education should be tailored to 'content central to survival' such as knowledge to do with the nature of the illness, risk factor change and prescribed drug effects. Specific content areas of knowledge concerned with recovery have been identified through the learning needs research. Bubela et al (1990) through the development of a learning needs scale from acute care patients at the time of their discharge, identified seven knowledge

areas: medications; activities of living; feelings related to condition; community and follow-up; treatment and complications; enhancing quality of life and skin care.

Summarising the work done in the patient information field in the UK up to the present day, Olszewski and Jones (1998) pointed out that the information most frequently wanted by patients was clinical information such as diagnosis, prognosis, risks and care and treatment after discharge from hospital. They stressed that it appeared that such information was not to enable patients to make decisions about their treatments but was to do with helping them manage the social, psychological and financial constraints of their condition. There was a lack of social research which actually discovers how patients make use of the information. The learning experience of the patient is a neglected area of study. A reflection of this state of affairs is the limited quantity of literature which focuses specifically upon knowledge of recovery experiences. The researcher intends to look at this literature as well as garnering sources to do with the change experiences of patients in a variety of contexts with a view to exploring the nature of the 'doing' of recovery.

Criddle (1993, p211) deduced that a process of recovery after surgery had been taking place for her post-surgical patient respondents because three main themes were raised by them. These Criddle postulated were 'active participation', 'achieving balance' and 'evolving beyond'. These were overlapping experience themes with no fixed time schedule. Active participation as part of a process experience was evoked through descriptions of for example: needing to be in control and losing control of one's body through surgical intervention; the need for some time alone, keeping people away; of seeing one's recovery as unique; developing and keeping a positive attitude; having accurate information and being able to identify some tangible improvement in one's condition. Achieving balance was to do with the presentation of attempts to achieve mind and body harmony; dealing with the dilemma of finding the right balance between activity and inactivity, dependence and independence. Within the theme of Evolving beyond, Criddle placed responses which seemed related to finding meaning of the experience of recovering from surgery. This took the form, for example, of seeing the experience as a form of self reflection and reassessment of beliefs and values. Most of these descriptions seem formed from specific practice experience but it is also worth noting that they were garnered from interview data and that the cultural context was that of the US. It is likely that that country's emphasis



upon individualism, self-fulfillment and psycho-analysis influenced what and why something was said.

Baker (1989) through pre-discharge interviews and a series of post-discharge telephone interviews, sought to collect descriptions of surgical patients' experiences of recovery after they had gone home. All twenty-five respondents had had elective cholecystectomies and were discharged between three and nine days postoperatively. From the descriptions collected, Baker constructed a 'Returning to normal' model of progressive and overlapping phases of 'passivity' through to 'activity resumption' and finally 'stabilization'. (Baker, 1989, p188). Each phase was described in terms of changes in the patient's physical and psycho-social state. The changing experience of fatigue and boredom and frustration were particularly emphasised.

Interestingly, in light of what has been examined previously relating to accounts of health and illness, 'major tasks' were mooted as a further aspect of the changes that were associated with recovery. These included the work of the first period at home- 'enduring' and 'resting'. Phase progression involved decision-making work concerned with doing more as well as testing out the limits of what one was capable of. Some difficulty in interpreting the cues of one's own body and those given by the health professionals, was identified. Sometimes, due to the contextual pressures of commitment to family, work etc., some respondents reported that they ignored the physiological cues (eg pain) that their limit had been reached. It would seem that the knowledges of recovering whether of the about, how or doing sorts only exist within a complex interactive context. A context characterised sometimes by for example, vague professional guidance, cultural expectations such as when to seek out the surgeon and financial pressures and the need to return to work. Knowledge of what recovering is, the practice of recovery, must, it is contended, include the social context of the surgical patient.

That recovering can be a difficult learning experience, was identified in a study which sought out the experiential learning process involved in diabetes self-management (Price 1993). Four stages to the 'getting regulated' process were identified in which a fully successful recovery resulted in the person establishing a self-management 'works for me' routine. Price found that a crossroads in the process seemed to be experienced in which some people settled for a less than successful 'good enough' routine and others went on to

recognise a pattern of bodily responses from which to 'plot' their management. The latter were able then to establish a 'basic routine' which consisted of 'a reliable repertoire of experiences.....grounded in both practice and principle' (Price 1993 p49). The 'good enough' routine was one which was described by Price's participants as an activity outwith their everyday living experience. Crucially the ongoing practice of this routine did not lead to further progression in the form of being able to deal with new diabetic situations. From this it could be suggested that 'recovering well' may be about obtaining experiences which are embedded in the patient's everyday practice of living with the changes and limitations of one's body. Further, the successful practice of living with these seems to be a process of participation in the full complexity of relations that exist in one's social and cultural context.

The importance of 'routine' was, according to Robinson (1993), a crucial strategy in the practice of 'doing normal things' by people with chronic conditions. The very activity of carrying out a routine also helped to normalise such experiences as hospitalisation. According to accounts from spinal cord injury young people undergoing rehabilitation, keeping to day-to-day routines was achieved through strategies they and their fellow patients had devised independently of the health care professionals as part of their effort to appear normal (Dewis 1989). Going out to the pub with friends without fear of being visibly disabled through bladder incontinence was ensured by 'accidentally' spilling beer on one's trousers when the situation demanded it. According to Robinson (1993), such 'covering up' activity, is common in people seeking to achieve recovery or rehabilitation. Both Dewis (1989) and Robinson (1993) argued that this kind of activity should not to be seen as a refusal to accept one's altered self but as a refusal to have the disability get in the way of social interactions. Robinson (1993) in her analysis of accounts from chronically ill people and their families of how they manage their lives, identified making 'trade offs' as another 'normalizing' activity. Participants talked of making decisions as to what was more important to be able to do to have a life worth living. Trade offs were made such as using a wheelchair to get out to the shops with the family because what was most important to the individual was the social act of getting out and not that of being able to walk. The researcher suggests that the activity involved behind the choice of such strategies as well as the concomitant practice amounts to a process of learning which



makes people holders of a body of knowledge about the nature of successful recovering. Williams (1989) emphasised that the patient's social context had greater significance over his/her actual disability, arguing that it is the nature of the society and the person's perception of his/her place in that society that is the most significant. From this viewpoint full recovery has not been achieved until the person resumes his/her social roles in the world (Deeny and McCrea 1991). No matter the length or extent of the recovering needed for this, the recovery knowledge required must surely include that which pertains to the social world of the patient.

Given the importance of the social context of the patient, it seems pertinent that recovery knowledge will relate to the patient's social existence within the hospital ward as well as post-discharge. Of particular interest for this study is what recovery knowledge there may be which focuses upon the influence of the other patients in the institutional setting. Although not specifically commented upon in Farrell's (1991) comparative survey of patients and nurses' views concerning the needs of hospital patients, it was noted that the psychiatric and general patients had a statistically significant higher (than the nurses) perception of a need to know the other patients better. Dewis's (1989) spinal cord injured patients were equally divided as to the therapeutic benefits of being associated with fellow quadriplegics and paraplegics. Those who were positive reported that they were encouraged by seeing other patients working so hard and gaining improvements in their condition. One participant commented as to the communal sharing of physical disability vis-a-vis the outside world of physical 'normality'... 'Inside here, everybody is normal' (Dewis 1989, p393). The negative comments given relating to other patients were to do with feelings of depression and discouragement at seeing others worse off than themselves and sense of discomfort at doing better than they were. All the patients were very selective about whom in the patient group they associated with. The 'visibility' of other patients in relation to recovery as a learning experience, is explored further later in this chapter, in the section –context of recovery.

The presence of others undergoing similar recovery experiences may contribute to the individual patient's knowledge base. What that contribution is seems to be to do with insights into spectrums and continua of recovering (Roth 1964). In other words a shared recovery experience gives access to successful and less successful progression as well as to

the range of progression entailed in reaching a state of recovery suitable for discharge from the institution. Taking heed of the selecting activity of Dewis' participants, a particular knowledge of recovery attained through previous living in society, that is concerned with what constitutes 'successful' recovery, must contribute to what will be learned in that shared experience. Further Robinson (1993) noted that the recuperating context includes care professionals who are perceived by some chronic sick participants as obstructing 'trade off' activity. This was due to professionals holding different definitions of what constituted a successful recovery or 'normality'. Knowledge of recovery then, must be shaped and formulated by the individual's experience of the differing expectations within the hospital and other care contexts, as well as those of the wider society, as to what 'recovery' is and how it should be achieved. How these expectations and the relations that they generate may interact across social contexts will be taken up when recovering contexts are given specific attention.

### **Part 3: Socio-cultural learning theory**

Before examining the literature concerned with recovering contexts, the socio-cultural learning theory postulated by Lave and Wenger (1991), which will inform such an examination, will be addressed. The origins of this theory lie in the work of Vygotsky, a Russian psychologist and educationalist. Vygotsky proposed that the development of higher mental functioning and consciousness in children was socio-cultural in character. His theory was that there was a mechanism by which the social and cultural, changes human behavior (Werstch 1985). This mechanism was about a process of moving from what has been experienced at the interindividual level to an intraindividual level of activity which develops and changes through the 'external' participation with others. This participation was social interactional in nature and was considered by Vygotsky as most influential in small group or pair situations, with adults, or more advanced peers. His was an original psychological perspective in that instead of looking at the individual's actions and relating them to how he or she behaves socially he argued that, "The first problem is to show how the individual response emerges from the forms of collective life" (quoted in Werstch, 1985, p59). The cues, assumptions, hints and expectations communicated within a situation shared with others are 'internalized'. This internalisation was not about a straight transferral of external experience but was seen as a process of formation of the

‘intrapyschological ‘ plane (Werstch,1985. p64). According to Vygotsky, the individual has an inner private consciousness which is social interactional in character. He argued that structural aspects of social interaction such as question-answer organization are echoed in the inner dialogue of consciousness. Vygotsky’s concept of a ‘zone of proximal development’ was his elaboration of the nature of the relationship between interpsychological and intrapsychological functioning. This idea was to do with ascertaining the distance between where a child was in problem-solving skills and what his or her potential ability to problem solve under adult supervision or in collaboration with more advanced peers.

Lave and Wenger (1991) developed their situated activity theory of learning as beginning with a legitimate place of involvement with others in a community of practice. This location has to be one which enables the ‘newcomer’ to become peripherally involved in the practice of the community. Learning, they argued, was about beginning as a junior participant or member on the outer environs of the complex matrix of social and cultural relationships that are involved in a community of practice, and moving toward fuller participation in such a community. The newcomer would be in a learning situation of acceptance by and interaction with the experienced practitioners of the practice community. This initial membership they called legitimate peripheral participation. Legitimate peripherality results in the participant having access to a wide range of expert practice and at the same time being employed in activities which do not demand so much of him/her in time, effort or responsibility ( Lave and Wenger,1991.p110). Wenger (1990, p126) described legitimate peripheral participation as a ‘general analytical category which describes learning as a mode of engagement in practice, and which as such, cannot be said to be successful or unsuccessful. It is a descriptor of learning, whether or not it takes place in the context of an educational institution’

An apprenticeship experience is one example of legitimate peripheral participation. Marshall (1972) described the process of learning for butcher apprentices in terms of increasing participation in the meat preparation business. Different settings for learning butcher practice were observed -a trade school, the backroom area of supermarkets and meat markets in Turkey. She noted in all situations the importance for the apprentices of being engaged in the practice of meat production in settings that gave them access to a

range of experience in their peers and in the journeymen butchers. It was suggested that the apprentices got much from watching others and being watched themselves.

Instead of investigating learning in terms of cognitive processes, Lave and Wenger proposed a different perspective. This was to seek out what kinds of social relations produce a context which is conducive to learning. Hanks (1991, in foreword to Lave and Wenger, 1991) provided an elaboration of this perspective: 'Learning is a process that takes place in a participation framework, not in an individual mind. This means, among other things, that it is mediated by the differences of perspective among the co-participants. It is the community, or at least those participating in the learning context, who 'learn' under this definition.'

In Lave's situated learning theory the notion of context is a synthesis of activity theory, which focuses upon a historical relation between people engaged in socially and culturally constructed activity and the world, and phenomenological social theory which centres upon the activity of constructing the meaning of a situation by coparticipants involved in ongoing social interaction (Lave 1993, p19). The synthesis moves these ideas on from looking for the relation between people acting and the context in which they are acting to something much more integrative and at the same time broadening. The nature of a learning context needs to be identified through examining 'the relationships between local practices that contextualise the way people act together, both in and across contexts' (Lave 1993, P22). Rogoff (1995, p159) argued that the nature of learning and development is to be found in looking at 'how people participate in sociocultural activity and how they change their participation' The individual, his/her peers and the institutions with which they were involved need to be studied.

Learning, from this perspective, is experienced by all who are involved, no matter how much of an 'old timer' (Lave and Wenger 1991) or expert one is. A learning context does not need to be school-based or even an apprenticeship situation, as learning is seen as a specific characteristic of all practice, whether it be studying mathematics to everyday activities such as going shopping. All the participants who share an activity come to it with different levels and kinds of coparticipation and potentials for change and so there is with every activity even the possibility of something different learnt for each participant. Lave and Wenger (1991), argue that 'learning' cannot be boxed as happening to particular

people in particular situations, rather: 'participation in everyday life may be thought of as a process of changing understanding in practice, that is, as learning' (Lave in Chaiklin and Lave, 1993. p6)

Learning then, from a sociocultural perspective, is happening most of the time through taking part in everyday living. The researcher's hunch that asking surgical patients what they had 'learned' from their experience would not be a fruitful approach seems to be borne out given that 'learning' is relatively unrecognised as a consistent feature of 'doing' in the world. That learning takes place in any social context is a given in sociocultural educational theory. In relation to the research question, therefore, the study patients were going to learn. What they were going to learn, and how the researcher might gain an insight of what this learning was, was another matter. What it is that is learned is a complex entity as knowledge is always undergoing transformation with use. This may have implications for the analysis of the participants' accounts in that knowledge gained during the recovery experience is likely to be changed or transformed with talking about it in the social context of an interview. Accounts, according to Dingwall (1997), are the result of the inherent social instability of the interview in which the interviewees attempt to work out the roles and expectations of themselves and the research interviewer. In addition, the research interviewee's account has been described as likely to include 'motive talk' presented with a particular 'audience(s) in mind' (Silverman 1993). 'Audience(s)' may be located in the immediate interview situation (ie the perceived identity of the interviewer) (Briggs 1986; Jorgenson 1991)) or across social contexts, to, for example, the group of care staff who looked after the participant. While motives may be to do with, for example, giving a good account of one's own behaviour or out of loyalty, the behaviour of others. As a consequence, something of the nature of these accounts will reflect the dynamism of personal social relations being developed or reinterpreted. In other words, learning processes might be glimpsed which relate to the 'reality' of past recovery experiences as well as to later reinterpretations of that 'reality'

For cognitivism, a major learning theory in the West, context is confined to the conceptual structures of an individual's thinking and learning and the socio-cultural parts of context are not included. Lave (1993) elucidates the nature of learning and knowledge through addressing the assumptions and weaknesses of cognitive theory. She points out

that cognitive theorists take as a given that learning is a separate activity from everyday activity that people participate in. This assumption generates the view that the individual is not learning outwith set aside times and appointed places for such an activity. The influence of such a view of learning can be illustrated in for example, patient education evaluation studies which focus on particular teaching episodes planned and carried out by health professionals. Attempts are made to measure patient 'knowledge' by directly relating it to specific teaching inputs. Reference to other sorts of learning activity or other kinds of knowledge evinced are not attended to.

Lave (1993) made an interesting distinction between cognitive and sociocultural approaches to learning and knowledge. A cognitive approach, is to see knowledge as existing as stand alone entities in heads and books etc and learning is about internalising this knowledge. A sociocultural perspective, on the other hand sees learning as 'an engagement in changing processes of human activity' (Lave 1993, p12.) With the former it is the learning process that is seen as a source of complexity. In contrast, the latter, focuses upon the knowledge as problematic. From a sociocultural perspective, 'knowledge' is always changing, difficult to encapsulate.

What 'knowledge' of recovery is then, is problematic if viewed from a sociocultural perspective. It is not a discrete, easily measured thing. Most nursing research concerned with 'patient education' focuses upon patients learning professionally prioritised skills to do with achieving independence. Rather than to do with knowledge **of** recovery, it is about knowledge **for** recovery. The former being concerned with the nature of the recovery knowledge, whilst the latter is focused much more on the learning. Assessment of learning activity centres upon the visible achievement of specific physical and mental skills. The knowledge assessed is that which, it is assumed, has been learnt through a particular set of relations, that of nurse and patient. As a consequence, it could be argued that the true extent and character of recovery knowledge is not garnered.

Another criticism Lave leveled at cognitive theory was that there is a focus upon the transmission of existing knowledge but with no explanation for how new knowledge is developed. How socio-cultural theory addresses the issue of new knowledge, is in the emphasis upon change in communities of practice. Wenger (1990), argues that new



knowledge comes through the transformation processes inherent in collectivities. Using his observations of a medical claim processing office, he posited that there is continual change going on in practice communities. Simultaneously, there are continuous organising efforts to 're-produce' the community practice to deal with a new situation and ensure the stability of the community. These ongoing changes and stabilising moves are, Wenger pointed out, such an everyday characteristic of ongoing participation in practice, that they are often not noticed. Improvisation it is argued, is an inherent characteristic of participative practice. By renegotiating the world through practice that is always reflective and never automatic, participants are involved in remodeling or 're-productive' activity. In this way, Wenger argued, change is wrought and stability maintained.

Wenger(1990), described change and stability as taking place in two kinds of 'configurations'-visible and invisible. These respectively were configurations of reification found in institutional settings and configurations of participation, found in communities of practice. Configurations of participation were 'sources of stability' (Wenger, 1990. p153) in having predictable ways of participating and well understood conditions of being a member of the collectivity. As already referred to, (last page), communities of practice are also sources of change in the way they are configured, because of the ongoing, invisible negotiative and innovative realignment of practice. On the other hand, visible configurations of reification were to be found in institutions. As sources of stability, these are to do with rigid ways of doing and representing the rationales for practice, which are visibly displayed through, for example, routines and procedures. In such configurations sources of change are for example, through organisational audits, resulting in rethinks as to practice and ultimately some sort of organised and visible readjustment of practice. Wenger (1990) postulated that it was negotiatedness which was the most crucial aspect in the transfer of knowledge because: 'negotiated knowledge is already part of an ongoing transformation of the self with respect to the cultural world' (Wenger 1990, p115). He stipulated that the sort of negotiating activity needed for learning, is that which involves the negotiation of membership and identities of participation. These characteristics it is argued, are needed for a definition of understanding in practice. They are the constituents of what Wenger termed 'cultural transparency'. By this term it is meant that what aids learning is being given access to a membership, to a belonging within which meaning is a

product of relations of practice which themselves are continually evolving and producing new negotiated identities of participation. Belonging it is argued, helps people to learn. Having a coherent social identity of participation within a context of shared social practice is necessary for change and learning to happen. In view of this, organising or designing institutional settings to facilitate learning and change is not simply a case of making information more accessible or 'transparent' but of recognising that knowledge is socially organised and that greater transparency involves cultural and social reorganisation.

Wenger gives the example of an attempt by the claims company to raise the level of specialist knowledge by organising those with this knowledge into a separate group of expertise within the claims office. This measure was quickly reversed when it was discovered that the quality of work suffered because relations within the local community of practice of claims workers included enlisting the help of these experts who previously had been situated amongst all the other workers. This means perhaps that institutional reification needs to be more culturally in tune with the kinds of relations that operate within local communities of practice.

Wenger (1990, p173) described communities of practice as 'condensations of membership in a landscape of peripheralities that are definitional of identities all the way to non-membership.' Although he recognises that non-membership can be the cause of alienation for individuals, Wenger argued that it is a state that everyone experiences most of the time and that it should not be viewed so negatively. On the contrary, he sees shared practice amongst people with varying degrees of membership and non-membership as an essential counter balance to a 'core' membership who, he argues, in achieving expertise become 'blind to the limitations of practice' (p174). He suggests that greater attention should be paid by educationalists to teaching how to be a non-member. Meaning that everyone should learn 'how to co-construct expertise in the member/non-member relation' (p174). The researcher suggests that an illustration of Wenger's meaning within the care context would be that of patients, as non-members in relations with health professionals, as having the potential to convey something of the sociocultural 'reality' that affects people who are ill. A reality that professionals can lose sight of in their preoccupation with their practice.



Aside from the cognitivists' silence as to the emergence of new knowledge, there is, Lave (1993) pointed out, an assumption within the 'internalisation' theory of knowledge acquisition. This assumption is that there is a uniformity of knowledge and a homogeneity of learners and their goals and motives and individual meanings. The influence of context is not recognised. Knowledge of recovery and the learner/recovering patient cannot be understood in terms which do not recognise that context and its complexity. The utilisation of the socio-cultural learning perspective in addressing the recovery process seems appropriate. Patients in NHS wards are from all levels of society who converge upon a surgical ward at different times and for the same or different procedures. Fuhrur (1993) drew attention to the emotional aspects of being a newcomer in which how the others in the collectivity view them, may result in non-learning behaviours. In relation to patients' accounts of their recovery experience, sociocultural learning theory concerning failure to learn may be of pertinence in getting closer to any barriers to recovery that might have existed for a patient. To quote Lave (1993, p16) there may be barriers to learning, 'from anxiety, from the social delegitimation of learning or the learner, and from the retarding effects of denying learner access to connection between immediate appearances and broader, deeper social forces or to concrete interrelations within and across situations'.

#### **Part 4: The recovery context**

According to Wenger (1990), learning is a practice experience which takes place within and on intersections with different communities of practice. In the contexts of the hospital ward and home, recovery is a process of learning. From this perspective recovering is a practice experience. In the light of this, the distinction made in the professional literature between 'rehabilitation' and 'recovery' (Wilson-Barnett and Fordham 1982) seems inappropriate. Given that learning is a sociocultural experience (Lave and Wenger 1991), it seems useful to view 'recovery' and 'rehabilitation' as part of a continuum of patient activity involved in healing. Although a recent extensive literature survey identified a lack of research concerned with the patient's social context in or out of hospital, (Olszewski and Jones 1998), what research there is from the health care setting related to patient recovery or rehabilitation will be explored and elucidated with reference to sociocultural learning theory

Hill's (1978) definition of rehabilitation was composed of two steps. The first was the task of establishing capacity, the second a teaching-learning process of utilising capacity. By this was meant that the recovering process involved both instrumental and expressive components. From her comparative study of two wards, a medical rehabilitation unit and a renal unit, Hill (1978 p61), argued that the greatest emphasis in both wards, but particularly the renal ward, was upon the first part of the process which was medically dominated. This was due to the Western culture which 'values technology, rationality, doing and a future orientation' all characteristics of an acute model of medical care. In addition, the medical model also operated in how the second part of the recovery process was addressed. The consequence of this was that a teaching-learning process of utilising capacity was contextualised as an individualistic experience. The idea of an expressive component to the process, was conceptualised through the gathering of data to do with the belief systems of staff and patients and the kind of institutional policies in operation and linking these with the relationships between the health care staff and the patients. The nature or existence of relationships of community and culture within the patient group itself was not identified. Thus the potential breadth of interactiveness inherent within a social context was not fully identified. However, something of the relations between patients and staff was glimpsed in the comparison of the two wards. The lack of any kind of congruence of beliefs to do with illness causation and treatment between the carers and the patients in the medical rehabilitation unit contrasted with the shared belief in technology found between patients and staff in the renal unit.

The context of recovery in the hospital ward has been addressed in the sense of the kind of environment that has a good ward 'atmosphere'. Atmospheres, according to Whitaker (1985) are discernible through what is said, how it is said and by the way people act. They can only come from the membership of a group, either sparked off by some significant event or built up through a particular themed interaction within the group. According to Whitaker, spontaneity is a key feature of 'atmosphere'. This view aligns well with Wenger's (1990) idea that the emergence of communities of practice can only be spontaneous and not orchestrated by professionals. Corroboration as to the nature of 'atmosphere' is to be found in a much earlier work by Schachter (1959). In his study of human affiliation, he found that anxiety was amenable to social influence and that within a

group of people, social interaction results in an increasing 'homogenization of feeling' (Schachter 1959.p133)

In contrast to the idea of the spontaneous generation of 'atmosphere', there is a perspective within health care literature which assumes that atmospheres can be engineered from outwith the group of people involved. Coutts and Hardy (1985) included a 'conductive atmosphere' as part of a recipe of items which would promote therapeutic communication. How it could be achieved was by the design and control of the physical environment. This could be done, it was suggested by, for example, reducing noise levels and controlling the 'presence of others' to encourage one to one interaction or by furniture arrangement. The notion that some sort of therapeutic atmosphere could be designed into a care setting has been a significant influence in how care of the elderly settings have been described and evaluated in the nursing literature.

The assumption that 'atmospheres' can be created or manipulated underlies work on the development of tests and scales to measure treatment environments (Moos1974, 1996). There is much of relevance to the sociocultural exploration of context to be found in the Ward Atmosphere Scale developed by Moos (1974). The scale had been tested and devised through focusing upon the environments of psychiatric wards in the US. What is interesting about it is that whether scored at the top or the bottom of the scale, it was a given that there was a community of **relations** being assessed. Patients were asked about the activities of all those involved in the ward, patients as well as staff. The presence of others was explicitly focused upon. Such work was influenced by the theory underlying psychiatric and correctional therapeutic community milieu therapy, that the social environment has a major influence upon behavioural disorders of people placed in these settings. The concept of therapeutic community developed from two related streams within British psychiatry. One stream pioneered by Main (1946) and Bion (1961) was focused upon the psychoanalytic tradition and in the therapeutic communities they set up the therapist had a central role which was interpretive and sometimes directive. (Clarke 1994). The other stream was developed by Maxwell Jones and focused primarily upon the treatment of personality disorders and the therapeutic community was founded upon the ethos of the 'maximal participation by patients in the management of the ward and maximal use of the patient community as an agent of change for individual patients' (Tuck

and Keels 1992 p52). From these two approaches there developed a practising social psychiatry and from this the study of groups and the significance of social systems in the health or illness of individuals (Clarke 1993). Although there has been little agreement as to defining the therapeutic community and efforts to understand it have been largely theoretical or confined to small-scale research of specific aspects, Maxwell Jones' view of what constitutes a therapeutic community seems to be the accepted basis of most definitions (Clarke 1994).

Maxwell Jones focused upon learning about the patient through observing him/her in relationships with others in a relatively familiar social environment. Observations were then fed back to the patient concerning the effect he/she had on others with a view to helping the patient gain insight about him/herself (Yurkovich 1989). To enable this a therapeutic community had to have particular characteristics. Relationships within the community had to be similar to those experienced in the world. It needed to be a 'microcosm' of the real world. Patients would become their own change agents and decide upon how they would change. The whole community is relevant to the recovery of the patient through interactions spontaneous or planned. In the latter category, are regular group meetings. Decision-making is a shared, democratic activity through ensuring the removal of traditional roles and hierarchies so as to enable the maximum communication amongst all participants (Rappaport 1960; Yurkovich 1989; Clarke 1994).

The emphasis upon the importance of the ward community as a whole and attention to its complexity of relations in helping people to get better, makes the concept of therapeutic communities of some pertinence to an exploration of recovery contexts. Therapeutic communities are planned social structures and to some extent the interactions within them are also planned. There is a recognition of the relevance and value of the spontaneity of interactions by people sharing an environment. However, in such a structured context designed to treat/rehabilitate people, there are likely to be conditions as the nature of acceptable spontaneity. Chapman (1988), suggests something of a counter-culture could exist in such 'shared' contexts in the form of 'strategies of resistance' to everyday communal activities such as not talking in community meetings.

It is suggested that the therapeutic community is an institutionally orchestrated configuration of participation (Wenger 1990). The 'normalization' philosophy is

operationalised through the emphasis upon domestic routines and is really a configuration of reification which functions to manipulate or construct into being, a particular communality which is acceptable to the professional carers. Most of the research that has been carried out has been by practitioners (Clarke 1994). It is mooted that behind the professionally orchestrated participativeness there lies a local community of practice of patients amongst which there are relations of practice. These relations of practice are to do with for example, ways to behave or appearing to behave within the therapeutic community's prescriptions of practice or seeking to work out the therapeutic 'timetable' (Roth 1964). In other words, patients are likely to be involved in a 'deeper engagement in communal practices that align the dynamics of identity construction and interpersonal relations with the stated purpose of the community' Wenger(1990) argued that a community of practice is re-produced by the **practitioners** and therefore is a response to, rather than a result of external design.

It is hypothesised that the community meetings in some therapeutic communities in which the reification is so disconnected from practice could be 'a substitute for actual engagement' in participative practice (Wenger 1990 p80). By this is meant that patients may form particular identities of non-participation in relation to the visible configuration of reification that is the community meeting. The disconnectedness of the institutional reification as to ways of relating and participating with others may mean that the community meeting represents only a very superficial layer of relations of practice, to do with resistance or 'working the system' perhaps, and not the deeper and richer frameworks of a collectivity. Collectivities being the relational frameworks within which new knowledge of practice emerges. Chapman (1988) noted that the time when there was the greatest amount of non-participative behaviour (i.e. violence and resistance to routine) in one therapeutic community, took place at times when patients were being admitted or discharged. It was suggested that nurses, in general as well as psychiatric wards, should pay closer attention to what is happening to the patient group in interactional terms at those times. It could be argued that something of the usually invisible participative practice may be discerned at those times, something of the relations and boundaries of a community of practice (Wenger 1990).

Like Hill (1978), Davis (1980) argued that in the West the acute medical model of care dominated the delivery of care in hospitals. This ideology of care was seen as inappropriately applied to all patients at all times in the progress of their illnesses. Davis pointed out that all patients, to recover, needed some sort of rehabilitative part in their care at some point in their recovery and indeed others needed a life-long participative role in their care. Patient participation was described as including such activities as 'knowing what questions to ask relevant to treatment and self-progress; understanding the care structure around him; knowing which staff persons to ask information of; recognizing the relationship between his behaviour and his health outcome; and being willing to learn about aspects of his care in order to assume responsibility for himself after discharge' (Davis 1980 pp40-41)

From a field observation study of a range of clinical settings, acute through to long-term, Davis (1980) sought to identify how health professionals could promote such patient participation activity and argued that what she observed in a rehabilitative setting which achieved this could be generated in any acute care setting. How this could be done was through various means such as maximising staff-patient interaction and ensuring a high visibility of rehabilitative activities amongst staff and patients. This was termed the 'fishbowl' effect, which encouraged patient-patient comparisons and an 'instant measure' of one's own progress. It was noted that patients 'compared notes' and were aware of the need for other patients with the same conditions to be present in the ward for this to be possible. Further interactivity could be encouraged by building in events which brought all participants together including relatives, for example 'goal setting conferences'. Further visibility could be achieved by making more explicit what the staff expected of the patients. This would be aided by a clearly communicated ward philosophy of care.

Continuity of care through increasing the involvement of the patient was at the crux of this philosophy. The primary rehabilitation nurse was regarded as the main 'ideology bearer'. Of particular interest is how in a unit in which only the primary nurses were permanently placed, measures were taken to promote adherence to this philosophy. These measures included a week's orientation with a primary nurse and using the ward log to communicate with her when she was not on duty. Davis (1980. P46) described the log as 'an effective manoeuvre which provided the temporary nursing staff an opportunity to



participate in the 'human drama',...of the 'rehab' ward. And in so doing, it seemed to have the positive effect of generating a commitment however transient from them to rehabilitative care measures'. In this way a social context was created which promoted a sense of membership amongst carers.

There is much about Davis' ideas of increasing patient participation which relates well to a theory of legitimate peripheral participation and the need for cultural transparency and membership to promote and legitimate such learning activity. Although, what was addressed most particularly was concerned with instigating configurations of reification (institutional philosophy, meetings, organising visibility of staff-patient activities) 'patient participation' was conceptualised on a broad framework of carer-patient and patient-patient relationships. However, patient participation within the patient group was only lightly touched upon.

Continuing the theme of therapeutic context, the presence and involvement of other patients in the recovery of the individual needs to be examined further from a social support perspective. As Oakley (1992) pointed out, the existence of social relationships does not necessarily ensure social support. Alternatively, social support can sometimes be more burdensome than therapeutic. For example the strong social relationship of family does not guarantee a supportive experience with family members when one is ill. In their exploration of social networks, Albrecht and Adelman (1987p250) posit the idea of there being a 'contagion effect' where members of a social network may be adversely affected by the distress of another member. Given the communal situation of the hospital ward, vulnerability to such an experience is a possibility. Watt (1996 p52) illustrated his fear of being 'confronted with other people's pain' describing what he could hear of another patient's experience of medical care:

'I sometimes blocked my ears with my fingers when the curtains were drawn around other beds. Someone came to fit a drip into Gwen's arm late one night. Gwen was very old and tiny like a bird, and her bowel was twisted. She spoke so kindly to everyone in her quiet high fluty voice. ....I knew the drip fitting would be painful and I had seen her small thin arms. But when the voice said, 'Hold still' I really couldn't bear to listen to her sharp gasps and gentle cries of shock and pain. They were like high, soft, falling scales of melody. It made my own anguish seem so boorish'



Another slant upon the presence and involvement of other patients in the recovering process which may be less than therapeutic, centres upon the possibility of the labelling and stereotyping of a patient by other patients. Jones et al (1997) identified this as an unresearched area in the nursing literature.

According to Albrecht and Adelman (1987.p19) therapeutic social support should provide: 'verbal and non-verbal communication between recipients and providers that reduces uncertainty about the situation, the self, the other, or the relationship, and functions to enhance a perception of personal control in one's life experience' A variety of kinds of contact is seen as most beneficial for the individual - 'breadth of contact, freedom of expression, information, yet retain anchoring qualities that enable the individual to feel a sense of reinforcement, belonging and commitment' (Albrecht and Adelman 1987. P59). From this description processes of social support seem very similar to that of learning as conceptualised in sociocultural learning theory. Having the opportunity to communicate with others who have, between them, a heterogeneity of experience relates well to Wenger's (1990, p148) conceptualisation of peripheries as 'locations with complex textures' at which identities of participation and belonging are negotiated.

The emphasis upon the characteristics of therapeutic relationships between nurse and patient will be explored later in this review ('Role of the nurse' Part 6). This emphasis tends to lean towards what has been termed an 'ideology of intimacy' (Adelman et al 1987 p127) whereby close relationships are the main focus in the study of social support. This has resulted in little examination of the role of weaker relationships as socially supportive experiences. Adelman et al (1987) argue that there are many weaker social ties that people interact within in their everyday lives which are of great importance. Because they are 'noninterpersonal' in character, in which communication is based upon quite stereotyped social and cultural information about the participants, little effort is necessary for these relationships to function in a supportive way. This also means that an individual can participate in many of these weaker relationships. Such relationships can enable learning because the participant has less emotional investment in them and the greater freedom provides opportunities to try out new ways of doing and have a wider access to information.

From a sociocultural learning perspective the community functions of less close social relations elucidated by Adelman et al (1987), seems pertinent. Unlike close relationships which tend to be between people with similar backgrounds, values etc, weak relationships, on the other hand are not so dependent upon similarities. They tend to be less connected to the individual's wider network and so there is less need for similarities. As a consequence, it is argued, social comparisons are made with dissimilar others. According to Adelman this heterogeneity and exposure to difference, is facilitative of social support through the new information it brings. From a sociocultural perspective heterogeneity enables greater opportunities for learning because there is communicative access to a wider source of experience. The restrictive relational character and the context restrictive characteristics of weaker relationships are, it can be argued, congruent with a group of surgical patients in a hospital ward. At any point in time, the patient group has a relatively heterogenous profile. Apart from coming from a wide social spectrum, surgical patients are heterogenous in their experience of a range of surgical procedures and dissimilar too in a generational sense in where they are situated in the process of surgical care. At the same time there is also some degree of homogeneity amongst surgical patients particularly in wards dealing with a specific surgical speciality, in that most will have had the same operation. Given this social context, the recovering experience is likely to be a complex social experience, much of which may be centred upon comparative work amongst the patients.

As already mentioned, Roth (1963) described how TB patients constructed treatment 'timetables' of how long particular aspects of their treatment would take with the aim of imposing some degree of predictability over an uncertain future. These timetables were the outcome of a categorization system built up through observation and comparison of the 'careers' of other patients in the sanatorium. Apart from overall timetables with which the patient could compare himself with anyone in the sanatorium, Roth found that patients also soon discovered which of their peers were having a similar treatment and sought to predict their own discharge by developing their personal timetable based upon what had been learned about the careers of these 'similar' patients. If it became apparent that a new treatment prescription was being instituted for them the timetable would be altered applying information about new 'bench marks' as to the nature of their progression through their illness. These 'benchmarks' would be gleaned from more comparative work

vis-a-vis themselves and the fate of 'similar' others. Roth argued that the clues that were accumulated by patients through communication and observation, about hospital life and treatment programmes became a group product. This knowledge base provided norms as to when recovery progression and treatment regimens should happen. Awareness of such norms also resulted in continual bargaining and negotiative activity between patients and doctors as patients tried to keep to or speed up their treatment schedule with doctors who had more differentiated treatment categories. The timetabled convalescence however, was not always an accurate picture of patient activity, as patients would surreptitiously try out a new, yet restricted activity. However, the privileges and restrictions of each stage of the recovery programme were viewed as very important by the patients as symbols of their progress. Such timetabling work can be interpreted as participative learning activity and the patient group as a particular community whose 'practice' is recovering. Similar patient participative activity has been described by Davis (1963) of convalescing young paralytic polio sufferers. Davis noted that when the acute phase of the illness was over the patients and their parents had no knowledge as to what to expect as to the time and degree of recovery. Again the child patients learnt what they needed to know mainly from the other patients in the ward.

The participative activity of patients is glimpsed in a study of cardiac rehabilitation patients who had witnessed the emergency resuscitation of one of their peers. (Badger 1994). There are glimpses within this of patients seeking to establish some degree of stability into a less than predictable recovery context. This can be seen, it is suggested, in what was termed 'downward comparison' where patients placed themselves at the less critical and more predictable end of the range of cardiac conditions and treatments. Those patients with unstable conditions appeared to present knowledge gained through observation of peer resuscitation and post-resuscitation and post-surgery recoveries of their peers in the expressed wish to have a heart attack and 'get the pain over' or undergo surgery so as to feel better (Badger 1994.p47).

In examining the value of 'weak' relationships, Adelman et al (1987) also considered them very important for the promotion of the perception of a sense of community. It is argued that one way in which this happens is by being able to hold many different contacts which put one in touch with the situations and views of a diversity of people and groups.

This results in making one more aware, more sensitive to those outwith one's primary network of relationships. The greater degree of knowledge of community-wide concerns and successes 'creates a sense of larger identification' (Adelman 1987 p136). This aspect of the social context of recovery, relates to the importance of belonging, of membership for learning to happen (Lave and Wenger 1991).

Apart from the literature to do with therapeutic communities, no health care research which dealt directly with the idea of membership and hospital recovery could be found. This finding is explicable to some extent, when it is recognised that individualised care is the 'sacred cow' of nursing (Reed 1992 p8). It is to be remembered that prior to this model of care the communal aspects of patient care were to do with treating patients as a homogenous group whose care was divided up into collective tasks such as 'doing the teeth' or 'the back round'. However, to recognise the heterogeneity of patients only through a personalised one to one relationship of nurse and patient has been to ignore that collective heterogeneity that is the patient's experience. Although there has been much written about the patient's participation in his care (Brearley 1990) this has been in the main to do with patient-carer relations and not about perhaps the less unequal relationship between patients. Nelson's (1990) study of the subculture of a spinal cord rehabilitation unit does, to some extent, attend to the patient-patient relations. Analysis of the findings made use of the work of Davis (1980). Comparison and even competition was noted amongst the patients. The process of 'reintegration' was divided into four phases- 'buffering', 'transcending', 'toughening up' and 'launching'. The 'older injuries' patients were observed to be providing an important part in the 'toughening up' process of the 'newer injuries'. This 'toughening' was described as focusing 'on compensating for the physical limitations, gaining independence and maintaining social interactions without 'using the disability' (Nelson 1990 p88). 'Older injuries' were described as employing a range of tactics such as 'negative feedback' and teasing towards the newer patients. Three forms of context which promoted recovery were described and were congruent with Davis' (1980) case that social environments can be designed. Staff sought to ensure the visibility of their interactions with the more experienced patients, a rehabilitation programme that operated to promote close contact between old and new injuries and a social environment which 'fostered a taboo against depression, anger and general

complaining behaviour' (Nelson 1990p193). More experienced patients were used by the staff as 'ideology pushers' to promote the positive philosophy of the unit (Nelson 1990 p83).

Aside from the potential for possible problems related to teasing and 'negative feedback', in this 'supportive' social context, there is no exploration of the reciprocity of the patient-patient relations. In other words, what does their participative activity do for the 'old injuries'. There is a good deal of institutional control exerted in the promotion and maintenance of this participative context. A patient community of practice seemed to have been discovered by Nelson which was at least partially manipulated by the professional 'outsiders'. A configuration of reification seems an appropriate description of what was happening. Wenger's (1990) view that communities of practice are spontaneous entities seems in direct contrast to the at least partially manipulated context described by Nelson and advocated by Davis (1980). However, according to Lave and Wenger (1991), the findings from the rehabilitation unit could be viewed as an example not of institutional design but of the 'alignment' (Wenger 1990 p170) of reification activities with the practice of the disabled group of patients. This alignment comes about through professional recognition of 'what works' in that practice community involved in the 'doing' of recovery. Learning to recover cannot be packaged as happening to particular people in particular situations (Lave and Wenger 1991). However, it is to be remembered that change and stability happen in configurations of reification and participation, (Wenger 1990) and it is mooted that, what has really been researched in Nelson's (1990) study, has been the former.

A further insight into the nature of configurations of reification in care settings comes in a participant observation study of bedside nursing 'handovers' and ward rounds (Latimer 1997). Nursing and medical behaviour was observed in an acute medical unit and the documentary follow up of the patients involved was examined from medical and nursing notes. It was found that during ward rounds and bedside handovers there was, through discursive practices, attempts made to 'move' (from Lyotard) the identities of the patients. Nurses were particularly involved in aligning and realigning the patient's identity in relation to the relative 'acuteness' of his or her condition. Latimer suggested that there was an organised motility to the identities of the patients which functioned to promote

particular forms of organisation . At ward rounds a 'disposal' decision came up when the patient had been 'figured' to have no medical future. Latimer addressed the question of whether it is the 'social structure of the ward' that determined how the medical and nursing staff 'constitute classes to enable their disposal work' or whether it was an 'effect of action and talk' (Latimer 1997 p187) and argued that it can never be known which comes first. Nurses were the agents who push the patients through but who were rarely told to move patients into a different class of care. ('acute' to 'social') They were described as making 'readings' which resulted in 'moving' the patient's identity in relation to the ultimate decision to discharge him from the hospital.

These findings are congruent with the much earlier work of Hill (1978) and Davis(1980) as they relate to the focus upon an acute model of medical care and the emphasis within this model on movement and futures. Where they differ is how not only the reduced need for acute technological support, but also 'psycho-social' details were used to change patients' 'identities'. In this way it was observed that a patient can be 'transformed' into a 'person' meaning someone with no medical future. Such a person was 'social' and not 'acute' and therefore 'becomes' disposable. Sociocultural knowledge that the nurses gleaned about the patient through communication with him/her was not necessarily used to improve care but as a way to keep him moving through the ward towards the door. An exit that Latimer found some patients were not ready for.

What was observed to be happening in the acute medical ward, was the visible procedural ways of organising where and when decisions would be made about a patient's position vis-a-vis medical care. At the same time the invisible configuration of practice, the discursive, and negotiative work in which the nurse was found to have a pivotal role, was observed. Patients' 'identities' were apparently dependent upon how nurses 'read' the social context. Patients seemed to play no active part in the decisions as to their futures. Given the invisibility of the 'readings' this would not be unexpected in such a social context lacking in cultural transparency. However, as discovered from Roth's (1963) study, patients are likely to busy making their own readings of the social context.

Strauss et al's (1985) concept of illness trajectories is insightful in an exploration of the social context of recovery. 'Trajectory' relates to the organization of work involved in the care of a sick person as well as to the physiological progression of the illness.



Different trajectories were necessary for different kinds of illness. The 'arc of work' was the term given to the overall scheme of work that needed to be done to treat and rehabilitate the patient home. Different kinds of work were observed being carried out by different people- health professionals, relatives and the patients themselves- which involved or generated 'instrumental' and 'expressive kinds' of relationships amongst the workers. Of particular interest in relation to this review of the social context is the little explored work carried out by patients.

Strauss et al (1985) found that much of the work carried out by patients was relatively 'invisible' and unrecognised by the care professionals, for example 'cooperative' work. An illustration of this comes from a patient source in Watt's (1996) account of his effort to be in control of his fear when he found himself having a liver aspiration in his ward and not in theatre under general anaesthetic. Strauss et al (1986 p197) found that patients can get into trouble with the care staff if they do not carry out such work and gave the example of the patient who is aware that he is dying and would be expected (though not recognised) to maintain composure so as not to 'be excessively disturbing for the staff's medical work, for its composure too, and perhaps, even disruptive of other patients' poise'

From this 'work' perspective, patients are very much engaged in the 'trajectory process'. That patients carried out types of work was not enough to describe this engagement. The patient work was described as part of a division of labour within the care setting. Such work as 'mirror image'; 'supplementary'; 'substitute'; 'necessary' and 'rectify staff errors' were some of the kinds of patient work which contributed to a picture of the complexity of patient-staff relations. Another engagement was found which was not directly part of these relations. This was the relationships which developed between patients. These too were viewed as involving forms of patient work. Like Hill's (1978) observation of renal patients, Strauss et al (1985) observed dialysis patients watching out for each other, calling on the staff if there was any sign of a problem developing. It was also noted that patients would group together in the absence or failure of the carers' work and would, for example, call on a nurse when medication for another, less alert patient had been missed or decide upon a strategy of whom to ask for help amongst the care staff. A 'we' group feeling was reported by patients.



Rather than looking upon the ‘arc’ of work involved in an illness trajectory as the division of labour between carer and patient, Strauss et al (1985) suggested that what should be investigated was how does patient work ‘fit in with the staff’s work and in relation to their mutual shaping of trajectories’. One type of patient work which was identified was ‘work outside the range of what the staff see as the locus of their own work’. This was very much to do with the expressive and emotional forms of work needed to be done by patients to deal with the changes to themselves that illness imposes. Given how this relates to the second part of Hill’s definition of rehabilitation, and to sociocultural learning theory, Strauss’s suggestion about the ‘fit’ of patients’ work is likely to be a fruitful line of analysis of research which seeks to address the nature of recovery. Further insight into what Strauss saw as a division of labour within the care setting could come from seeking out patients’ accounts of their ‘recovering’ experiences.

### **Part 5: Recovery narratives – literary sources.**

Turning to accounts of recovery, according to Bruner (1991), people structure their experiences and what they remember of happenings into narrative form, into stories, justifications, myths. Written narrative, for example, autobiography, biography or novel can be seen as reflecting something of the reality of the experience described. A ‘versimilitude’ as opposed to a verifiable composition of what happened (Bruner 1991, p4).

It is proposed that Bakhtin’s theory of dialogism which ‘assumes that every individual constitutes a particular place in the master dialogue of existence’ (Holquist 1990, p84), gives justification for the inclusion of literary works in this review of what has been written about patients’ experiences of recovery. In Bakhtin’s view, literature gives the least structure or order to the unordered environment in comparison to other forms of written work such as sociological or psychological texts. The latter, it is argued, are very narrow, overly structured by professional discourses which allow only one level of seeing and interpreting the world. Literary texts on the other hand, contain simultaneously different levels of dialogue or relations between self and society. Bakhtin was particularly interested in the novel because of its dependence upon intertextuality for its existence (Holquist, 1990, p89). This intertextuality is about the embedded relating of other texts to each other and the work. Intertextuality of course is present in other literature but is at its most

complex in, and is an essential characteristic of, the novel. Apart from the inclusion of other work, there is also an intertextuality of discourses from different stratas of society and times in history. From this perspective, the novel and other literary works could be presented as having a unique and authoritative place as a form of communication and therefore as a form of knowledge (Holquist 1990, pp 48-49).

Watt (1996), a famous young British pop star, wrote about his experience of a life-threatening illness. His narrative detailed the whole period of his life when he was afflicted by a rare disease which resulted in the virtual destruction of his small bowel. His external life of hospital, health care staff, family, friends and fellow patients is told in tandem with an internal narrative composed of thoughts, dreams, memories and fantasies which interweave with the external reality of being a patient. This narrative within a narrative seems to serve at times, as a written 'backward reach of responses' or 'reflexive frame break' (Goffman 1981, p42, p45)) to the main narrative which plots his patient 'career'. In other words, one frame or primary layer of reality was 'transformed' into another layering of experience in the form of a series of thought/dream narratives. Watt had undergone what seems to have been the whole gamut of medical care available from multiple investigations, emergency trips to see doctors, to intensive care monitoring and major abdominal surgery and a long and tortuous recovery. Goffman's concept of frames seems an appropriate way of interpreting Watt's narrative work to describe the complexity of his experience (Collins 1988).

From the socio-cultural learning perspective already discussed, it is suggested that configurations of reification and communities of practice were evoked within Watt's story. Institutional reification for example, was glimpsed in the following narrative:

'At first I couldn't understand why doctors weren't called every time I was in pain. The staff nurses were kind and the student nurses young and keen to help, but both were untrained in diagnosis and when I'd call one of them with my call button they could offer no answers and I would get fractious and upset. Nobody told me that, except in times of emergency the doctors only came round twice a day-once in the morning, once in the evening-and that only they could take big decisions. I had to learn the pace of the days' (Watt 1996, p12).

Something of the learning activity that was involved in the timetabling work that Roth's T.B. patients were engaged in is echoed here. In the same vein in 'The Bell Jar' Plath (1963) tells of Joan Greenwood working out the change in early morning procedural activity in the psychiatric ward which meant that a particular patient was to receive ECT. Configurations of an inmate community of practice seemed to be evoked for example, in the shared knowledge amongst her peer patients of the levels of madness associated with particular behaviours and sufferers housed in different hospital units.

Watt's story, 'Patient', was crowded with participant relations with doctors, nurses, family, fellow entertainment professionals and fellow hospital patients. Varying degrees of membership are communicated at different times in his illness experience. Before his first surgery, Watt portrays a person preoccupied with pain, fear and confusion. His social context was his relations with his body, the supportive presence of his girlfriend, and his mother. The points of contact with health professionals being ward rounds and visits from specialists. The lack of communication and learning that can happen because of a lack of 'cultural transparency' seems to be portrayed in this excerpt from Watt's work:

'That Friday two doctors from the London School of Hygiene and Tropical Medicine came down. They confidently assured me that, in spite of no conclusive proof, I was bound to have a parasitic infestation. Although one parasite had already been discounted, further tests in Glasgow would confirm it, they said. I lay on the bed talking to a room full of people. I felt silly talking while lying down, felt I ought to sit up at least, but my belly was tight with fluttering cramps. I felt sure they were wrong, but how could I say it? The doctor who talked the most had a full beard and a 'Save Africa' badge on his lapel. They were all eager to take me over to their hospital, which had no facilities for an emergency. I really thought they didn't have a clue.' (Watt 1996. P19)

The visiting specialists were presented as scientifically absorbed, and not indulging in a negotiatedness (Wenger 1990) which would acknowledge Watt as a legitimate participant in decisions about his medical care. What the knowledge potential could be if there was cultural transparency, seems to be exemplified in Watt's narrative of his later practice as a struggling to recover post-surgical patient:

'I would memorize my temperature movements and be able to quote them at the Prof to one decimal place to disarm him on ward round. After a while I could even guess my temperature quite accurately. I could feel it rising:

37.6...37.9 (learning to recognize the faint sickness it induced)

37.9....38.1(the loss of concentration and the desire to talk to anyone)

38.2....38.3(a slight fogging of the eyes and the dry, sucking aridity in my head and the back of my neck)

38.1...37.9 (the leveling out and the dropping off)

37.7 (a severe sweat during an afternoon nap, or in the middle of a restless night, maybe a pang of hunger, a need to piss seemingly incessantly, and the final falling back to...)

36.9...36.8 (like some calm valley after a long descent) (Watt 1996, p80)

From a sociocultural perspective it could be argued that there is a claim to 'membership' embedded in this narrative, meaning Watt's acknowledged wish to participate legitimately at ward rounds by way of his unacknowledged, participation in the diagnostic work of the doctors through use of procedural tools and routines of the institution. (i.e. temperature taking practice) (Wenger 1990). It also could be argued that another kind of membership is evoked in that these descriptions of what it is like for him to have a fever, are a description of practice, and as such, could serve to legitimate his identity as a patient. As he makes clear that this is a description built upon his extensive experience with fever and the professional monitoring which accompanies it, he may be claiming membership (albeit unconsciously), at the 'core' (Wenger 1990) of a patient-only community of practice as an 'old timer'.

'Patient' is an apt title for a story which conveys a sense of the lived world of the patient Ben Watt and the other patients who shared that world. Post-surgery there was a good deal of narrative to do with representing that sharing:

'As a group-perhaps only one of two of us talking, while the others in nearby beds listened- a bond would emerge in the periods between ward rounds and visiting times, away from the scrutiny of doctors and the quiet flustering of relatives. The bond's common

language was the wink, delivered across the room to the person opposite, as if to say, 'They all think we're ill, but we know we're all right. We're just having them on' (Watt 1996. p77).

The existence of other patients going through their own experience of illness, surgery and recovery was revealed. Their existence was in the supportive 'wink' or the shared listening to the audible discomfort of a patient having a naso-gastric tube inserted (see page 40 for relevant excerpt). A context of relations between patients to do with support, information giving, rehearsal and re-living past recovery and illness experiences could be identified as a particular community of practice.

## **Part 6: The role of the nurse**

In the final part of this review the literature concerned with the role of the nurse in helping patients to recover will now be explored. It is generally agreed that nurses have a role in the education of patients. What that role is seems unclear (Close 1988; Redman 1993; Olszewski and Jones 1998). Close's (1988) review of the literature found little clarity of role, arguing that most of what nurses did do in educating patients was 'haphazard' and 'unplanned' with little evaluation of the effectiveness of their input. According to Luker and Caress (1989) a good deal of patient education literature has been unresearched and prescriptive in nature. In other words, nurses were guided as to 'how to do' patient teaching (Luker and Caress 1989 p712). Nurses themselves have not been clear as to their role and argue amongst themselves as to where they operate in patient education vis-a-vis other health professionals (Tilley 1987). A decade later there is still a lack of role clarity. In their summary of the literature dealing with the provision of health information to patients, commissioned jointly by the Scottish Office and the Scottish Association of Health Councils, Olszewski and Jones (1998 p6) noted that research to date had not been illuminative as to the role of nurses as 'clinical information-givers.' The lack of clarity as to the role of nurses will be examined in the first instance by addressing the underlying assumptions as to the place of nurses in patient education. Then other ways to interpret the position of nurses will be explored within literature less obviously related to patient learning and recovery.

In much of the literature whether in the form of textbooks or research based materials, there is the assumption that 'patient teaching' involves a teacher-learner one-to-one relationship. There are problems with taking this view which are to do with the reality of health care provision. Luker and Caress (1989) argued that the lack of time available to nurses to become involved in such time-consuming activity makes such relationships unlikely. Increasingly, with shorter hospital stays, few convalescent places and the upsurge in day surgery, the time available to either patient or nurse has become shorter and more pressured (Noble 1991; Friend 1999). Jones et al. (1997) pointed out the difference between the context of relationship-building for nurses, doctors and therapists. They argued that nurses are in a constrained situation with a lack of privacy for confidences or the time to listen to them whilst therapists were able to deal with their patients singly and also chose those patients to work on, leaving behind in the ward the less rehabilitative clients to care for. The barriers to an effective learning relationship have also been identified in the patient-learner in the form of difficulties of concentration and memory due to biochemical changes of illness and anaesthesia in medical and surgical patients (Luker and Caress 1989). In addition, particular conditions, for example vascular disease, that patients are being treated for may present as the cause of learning difficulty.

There is also a tendency with the teacher-learner relationship approach, to write of 'patient teaching' as a one off event usually related to either pre-operative preparation or as part of a discharge planning procedure. This way of conceptualising patient education does not address the nature of learning as a process that proceeds **over** time (Adam 1990). Patients in practice become aware of their need for knowledge and go about seeking it over time (Olszewski and Jones 1998). Tilley (1987) pointed to the lack of preparation nurses have to educate suggesting the development of clinical nurse specialists, where 'a formalised programme of patient education is required'. Such nurses would liaise with the non-specialist nurses, and in that way, the latter would have a small but informed part in patients' learning. Redman (1993) reviewing North American data concerned with patient education, also noted a dearth of courses concerned with patient education. Apart from their lack of knowledge of recovery, already detailed in the previous section, nurses need to have better teaching skills (Noble 1991). This is demonstrated by the findings of some studies. Tilley (1987) found that nurses underestimate how much the patients do know.



Fleming (1992) described nurses as technicians carrying out what has been designed and developed elsewhere. In a study commissioned by the English Department of Health concerned with cardiac rehabilitation, nurses were described as givers of leaflets only (Newens 1995).

An alternative, more positive finding from research focused upon the nurse-patient/teacher-learner has been posited. Karlsen (1997) argues that what has been addressed in the patient education literature has been the 'ideals' of patient teaching which is based upon a formally structured teaching framework of assessment, planning, implementation and evaluation. Based upon interviews with registered nurses in a general hospital, two distinctive teaching processes, were revealed. These processes were linked to specific knowledge content and objectives. One was related to general information that nurses delivered to all patients. There was a routinised element to this process and distinctively, it was noted, that there was no assessment or planning involved. This kind of 'teaching' was frequently adopted for particular events such as admission to the ward. As already noted in the previous section, the content of such 'teaching' was standardised. Karlsen suggested that the main objective for adopting this teaching approach was to promote patient cooperation and make the nurses' jobs easier. A similar observation was made by Strauss et al (1985) through the study of the organization of work in hospitals.

The second teaching process identified by Karlsen (1997) was linked to the patient's individual need and was characterised by assessment and implementation phases but no planning. This was utilised with acute and chronically ill patients and seemed to be very much an opportunistic, ad hoc activity but was, at the same time, tailored to the assessed need of the patient for information at a particular moment in time. A further distinctive feature of this process was that it was described in terms of practice relations. The teaching was, as it were, an integral part of the practice of care.

Aside from Karlsen's (1997) work, there is a good deal of negativity concerning the nurse's role in patient education. However, the nurse's educative role may be inadequately addressed through the literature to do with the teacher-learner relationship. This situation could in part, be due to a more general problem with the concept of 'patient teaching'. That is the failure to acknowledge the presence of a context in which the learning takes place. Two notable exceptions were Rakel (1992, pp411-412) who in a skills analysis of the



nurse's educational role included the promotion of 'a conducive environment' and Redman (1993 p727), who in addressing the question of what is left to be done in the study of patient education, stated, 'There is really no adequate description of learning conditions under which education for patients takes place.....Perhaps even more important, there is virtually no longitudinal focus on learning over the course of a chronic illness'. Attention then, should be focused upon the social context of recovering on two counts. Firstly there is the context related to any recovering experience post-surgery and secondly, there are the contextual issues related to a sometimes lengthy recovery period post-surgery that many surgical patients with a concurrent chronic illness have to go through.

A consequence of using 'mainstream educational principles' (Luker and Caress 1989) in the conceptualisation of patient education has meant that it is strongly influenced by cognitive learning theory, (Lave 1993). This theory has already been discussed earlier in this chapter. When the learning process is addressed, whether directly or indirectly, the context in which it takes place comes more into view. It may be that an exploration of the role of the nurse in patient education would be more fruitful when issues of context are studied.

An aspect of context which has already been explored is that of the professional ideology of acute care (see Part 1). The dominance of this ideology has much to do with the strength of the doctor's position in all health care settings whether acute care is appropriate or not. (Hill 1978; Davis 1980; Strauss et al. 1985). How this philosophy may relate to the nurse's role in patient education lies in attending to the character of the working relationship between the nurse and patient. Strauss et al (1985) found that nurses got involved in teaching a patient something if it helped with staff work. Similarly, Doyle (1992) found that nurses taught patients as a mode of persuasion to understand their viewpoint. This teaching was seen as a negotiative tactic between nurse and patient. Such findings relate, it is posited, to the prescriptive pressures of the acute care ideology. 'Teaching' is resorted to by nurses practising in a contradictory context which demands passivity from patients who at various junctures in their illness or recovery, may be far from passive.

Pursuing the theme of working relations between patient and nurse, Strauss et al's (1985) observations of patient work posited that patients, contrary to the acute care

philosophy, were active and 'expert' participants in their care and sometimes in the care of other patients. Some of this work was to do with monitoring and supplementing the work of the nurse. Two examples of such patient work given by these researchers were providing one's own 'continuity of care' in the face of staff shifts and rotations and rectifying mistakes made by staff. Much of this patient work was described as 'invisible' or unrecognised by the care staff.

A study investigating the 'practical knowledge' of carers in nursing homes uncovered a large range of 'invisible' work carried out by carers (nurses, other patients and visitors) (Jackson 1997). This work, described as 'personal caring' was not included within the routinized and costed schedules of the institution. It consisted of such activities as 'putting on glasses' 'listening to troubles' 'offering a drink'. According to Jackson, a defining feature of this form of caring for the carers, was the existence of a relationship between patient and carer. In other words this sort of care was more likely if there was a sense of affinity with a particular patient. The practice of this kind of care then hinged upon social and cultural relations of context to do with notions such as 'deserving', and popular and unpopular patients ( Stockwell 1972 ; Jeffrey 1979)

The 'invisibility' of such relations of context was to do with there being no allowance made for it at an institutional level as 'it is neither scheduled, rewarded nor compensated' (Jackson1997, p199). It is suggested that it is in this area of informal care activity that nurses' involvement in patients recovering experience may be more to do with patient learning than the formally prescribed and visible 'patient teaching'. It may be that as Wenger (1990) contends, the less 'contaminated' the activity is with institutional mores of doing, the closer it is to the reality of practice within communities of practice. In other words, nurses' informal care work aligns more with an interactive context in which patients are participants.

The therapeutic characteristics of this informal interactive context may have been identified in Hinds and Moyer's (1997) exploration of cancer patients' experiences of support whilst undergoing radiotherapy treatments. From the analysis of interview data from these patients, a process of experiencing support emerged as 'an interpersonal process embedded in an array of social exchanges which involves encountering support, recognising support and feeling supported' (Hinds and Moyer 1997 p371). A complexity

of social and cultural mores or ways of doing were identified as operating as the context of helping actions. Three kinds of support were found. The first was 'being there' which was not just providing a presence, an attendance, but also an emotional component of 'being there for me'. The second form of support was the physical help of, for example, taking over housework tasks and the third, was information and advice giving. The main source of all types of support was seen as coming from family and friends with professional carers mainly ascribed a role as information-givers. These findings seem to contradict the body of nursing literature to do with the nurse-patient relationship which has emphasised the nurse's role in providing support, particularly emotional support to patients (Gibb and O'Brien 1990).

That nurses were not identified to any extent as giving emotional or physical support is explained by another finding from this study. This was to do with the recognition of support. What seemed to aid this was a disruption in the usual behaviour within a relationship such as a conspicuous action such as travelling a long way to visit. Within the nurse-patient relationship there may be multi-faceted supportive care but within the norms and expectations of that relationship it may not be recognised as such. In a study investigating what kind of nurse patients wanted, it was suggested that patients may take some nursing activities so much for granted that they do not notice them taking place (Webb and Hope 1994). The everyday informal nature of nursing care identified by Jackson (1997) may help to explain this lack of recognition for nurses. The 'recognition' presented by the cancer patients could be seen somehow as a function of the interviews, especially since they were carried out in the patients' homes. Nonetheless it is of relevance to this review that whatever or whoever the recognised source of support is, it may be the therapeutic effect of recognising that one is being supported that is potentially, a most significant finding in relation to patients' recovery experiences. Once support is recognised it is experienced as meeting a need and so produces, it is reported, therapeutic effects such as 'energizing' and confidence-boosting.

Why nurses' supportive work may not be noticed by patients may be to do with the essential character of the relationship that exists between nurse and patient. Aside perhaps from long term situations in which patients are in regular or constant contact with care professionals, the 'nurse-patient relationship' is not a close relationship. Close

relationships are more memorable and identifiable (Adelman et al 1987). The 'ideology of intimacy' has already been discussed in an earlier section. Instead of seeking out nursing's contribution to supporting patients with the view that it is only possible to do so through the development of a strong relationship with a patient, addressing the supportiveness of weaker links may be more fruitful.

According to Adelman et al (1987) the main characteristics of weaker relationships enable the individual to find support from a variety of sources involving less energy, and requiring less of the reciprocity of closer relationships. Weaker links are described as less 'portable' than strong ones as they are more likely to be contextually restricted, both in place and time. A greater anonymity comes from this and brings greater freedom to disclose about oneself. At the same time, in such a restricted context, Adelman (1987) notes that participants operate with fairly stereotypical social and cultural information about each other.

The application of these descriptions to an exploration of the nurse's role places the nurse within the patient's context which outside the close family and friend relations, is more likely to be supportive because there is restricted information and narrow expectations between participants. As the sociocultural context determines the meaning of the support (Ware and Kleinmann 1992) to the participants who are the givers, receivers and others in the care-setting, it would seem cogent to identify what the information and expectations are. As these are only formed and re-formed through the relations within a specific social context (Lave 1993), it is to be expected that the nurse's 'place' in the care setting will be subject to continuous redefinition. If the nurse's role is subject to change in one context, it must have many permutations across the many individual care contexts in which nurses and patients find themselves. If this is the case, then much of what has been written about 'the role of the nurse' seems to have been influenced by a professional ideology of individualism (Reed 1992) which focuses upon 'the relationship' stripped of its context. The parallels with the way 'patient education' and nurse's role in 'patient teaching' have been conceptualised are clear.

When context is specifically addressed then the nurse's role in the patient's recovering, learning experience, may be clarified. The notion of work has already been introduced (Strauss et al 1985) as it could impinge upon the relations between nurse and

patient. Viewing the context of recovery, as populated by workers, patients and carers, gives nurses a more identifiable part in the patient's recovering experience. The work perspective makes sense of the findings of research already cited which described nurses as 'technicians' and 'leaflet givers' (Fleming 1992; Newens 1995). From a work perspective, these descriptions are not necessarily negative about nursing's contribution. Dennis (1990 p165) saw nurses' role as 'fostering a flow of information even though they may not be the 'keepers' of the specific information'.

Gibbon and Thompson (1992) carried out a small survey of nurses' views of their role, working in a care of the elderly unit. Nurses viewed themselves as 'supporters' and 'reinforcers' in the rehabilitation of patients. No responses supported an independent role for nurses. Their rehabilitative role was located in a multidisciplinary approach. Wong and Wong (1985) focusing upon patient compliance with 'preoperative teaching', advocated that nurses should be 'education reinforcers'. Jones et al (1997) concluded from interviews and observations in a stroke rehabilitation ward, that nurses had a 'carry on' role, at the times when the various therapists were absent.

In two separate studies on the topic of rehabilitation which involved actual observation of the relations amongst the participants (Davis 1980 and Nelson 1990) nurses were identified as 'ideology bearers' (Davis) or 'ideology pushers' (Nelson), ensuring the continuous presence of a positive rehabilitative ethos amongst staff and patients. This perspective on the role of the nurse needs to be qualified in that the ideology 'pushed' may not address the expressive second part of the rehabilitation process Hill (1978). Helping patients to utilise capacity may not be assisted by a rehabilitation ethos which is heavily influenced by an acute medical model of recovery that contextualises recovery as an individualistic process. However, Nelson (1990) noted the nursing practice of enlisting 'old timer' patients to 'push' an ideology which centred upon the preparation of less experienced patients for bridging cultural contexts, moving from the protective environment of the ward to the outside world. The collaborative and negotiative work of such activity is social and cultural in character and is more likely, it can be argued, to promote learning which connects with the work of living that each patient faces on leaving the hospital.

Earlier in this section Jones et al's (1997) work was noted as distinguishing differences in context that the various care professionals operated with. Nurses were portrayed as disadvantaged in their opportunities to build relationships with their patients. However, such disadvantageous contextual features as the lack of privacy and having to look after a number of people at differing points in their illness 'trajectory' (Strauss 1985) may be viewed as placing nurses in an influential position with respect to patients learning to recover. This relates to the communal and organizational aspects of recovery experiences. Describing the role of the head nurse, Strauss et al (1985 p151) commented that the physician may devise the overall plan or 'blueprint trajectory' for each patient, but it is the head nurse who is the 'the key actor in the articulation drama'. By this was meant that there are medically prescribed stages to a patient's illness experience but how they will be experienced will be very much to do with exploiting to the patient's advantage, the 'social properties' of a hospital ward (Davis 1980).

Nurses' position, or potential position, in the relations of work involved in the many recovery trajectories in the ward is one of participant in a complex interactiveness as well as at least a partial manipulator and promoter of such communicative activity. This is possible according to Davis (1980) under certain conditions. These were for example: if nurses took advantage of the potentially high visibility of their work with patients vis-a-vis the other patients in ward enabling peer comparison and personal evaluation of performance and the 'timetabling' projections of one's recovery progress (Roth 1964). Nurses, according to Davis, should make very explicit what is expected of the patients. This could be done through the development of clear rules and routines to the process of rehabilitation and through the formulation of an explicit 'philosophy of care' which would be communicated to the patients and their relatives formally and informally (Davis 1980).

Maben et al (1993) noted that there was a lack of research to support the notion of the organization of care influencing the health education practice of nurses in acute wards. How this lack was addressed by these workers, was through making a comparative study of whether the way in which nursing was organised, did or did not promote such features as continuity of care and individual nurses' responsibility to ensure patients were exposed to 'health education practice'. From the findings of this study it was considered that nursing care organised around permanent team or primary nursing was most likely to



achieve these features. However, this recommendation seemed to be nullified with the researchers' final summary note which suggested that the institution of a 'named nurse' for each patient, would most likely deliver continuity and responsibility inside or outside the approved organisation of care. The influence of the professional 'ideology of intimacy' could be attributed to this suggestion. On the other hand, the research findings may have lent weight to the social support literature already reviewed in this chapter, in that the adoption of a 'named nurse' could provide the patient with a predictable nurse contact as part of the complexity of weak relationships that he/she may appreciate as 'supportive' in the hospital context.

Conceptualising the organisation of care, like a good deal of patient education and nurse-patient relationship literature, places the emphasis upon nurses making a difference. The exploration it seems, goes no further than a kind of cause and effect investigation in which all other variables are held constant. The named nurse system may contribute to a good recovering experience but its place within a context of many relations has not been explored.

The nurse's educational role in patient recovery may be sought within the conceptualisation of change and stability taking place in two kinds of 'configurations' Wenger (1990). According to this theory (which is fully explored in Part 3 of this chapter) configurations of participation are found in 'communities of practice'. The relations in these communities are configured in such a way that there is an ongoing negotiation and realignment of ways of doing, of practice. Apart from enabling change there is a source of stability in such collectivities in that part of the negotiative work is to do with acquiring a social identity as part of the community. Belonging, Wenger argued, was important for learning and is facilitated in configurations of participation because there are predictable ways of behaving and well understood conditions for membership. Configurations of reification are linked to institutional contexts. Reification is evinced in rigid ways of doing and representing rationales for practice. Such ways of configuring the social world are very 'visible' forms of stability. Examples of this are the routines and procedures and organisation mission statements to be found in institutional settings.

Relating such theory to the examination of the nurse's role in the recovering learning experience of patients is thought provoking. Nurses in rehabilitation and acute care areas

have been described as having the real or potential role of orchestrating patient learning experiences, (Davis1980) through increasing the visibility and accessibility to practice knowledge. By doing this they may be playing a part in the creation of a community of patient recovering practice. At the same time they might be described as contributing to the sociocultural experience of recovery by aiding recovery learning through facilitating the legitimate peripheral participation (Lave and Wenger 1991 ) of 'new' patients through the day-by-day implementation of highly visible care routines. Nurses' preoccupation with 'getting the work done' by the implementation of the routines and procedures of everyday ward activities is positioned at the boundary of what is the institution's reification system and that of patient work. Nursing work seems to function simultaneously in both reification and participation configurations which is at least partly to do with recognised and unrecognised forms of nursing care. In Jackson's (1997) study of the practical knowledge that was the basis of day to day care in five nursing homes in the USA, a considerable amount of the work of caring as understood by the carers, was not included in the administratively recognised care routines. Jackson termed this work 'personal caring' which was not scheduled or rewarded. How much of it took place was dependent upon the time available outwith the completion of the institutionally recognised care routines. Unrecognised nursing work was concerned with acts of personal care and kindness. Significantly, this activity was linked to either patients taking the initiative or to specific relationships that had developed between the carer and the patient. It might be that the social relations involved in such an activity could be placed within the invisible configuration of participation. From this contextual complexity, seeking out the position of nurses in the recovering experience of their patients is likely to involve looking for layers of relations within the context of recovery in which nurses act to a lesser or greater extent within either reified or participative configurations.

The pivotal role of nursing may also be to do with being a participant within another practice community, that of the professional carers. Nursing work, it could be suggested, may be to do with negotiating an 'alignment' (Wenger 1990 p170) between the patient community of practice and institutional and professional reification and participation configurations. According to Wenger (1990) alignment of institutional configurations with the practice of communities of participation is much more likely to result in learning

than through design. However, 'alignment' may be a theoretical ideal only, when one addresses the actual relations of practice which the nurse is involved in, within the professional and institutional community of practice. Latimer (1997) described how the nurses' role in an acute medical ward was to 'move' on patients toward discharge. This was an activity in which nurses had a distinctive role in 'figuring' the identity of the patient as 'patient' whilst he/she needed acute medical interventions and 'downgrading' him/her to a 'person' with 'social' as opposed to medical needs and therefore no longer requiring acute care. Nurses took what could be termed contextual 'readings' from what they saw and heard at occasions such as ward rounds, to make 'translations' as to whether to 'move' the patient on. Latimer (1997, p169) described the communicative activity amongst the professionals as aimed at organising 'a motility to the identities of patients as a means of helping to produce particular forms of organisation' Through their inclusion of their 'psycho-social' assessment information in their contribution to this activity, nurses were described as 'extending the medical gaze'.

It could be argued from such findings that instead of aligning professional and organisational relations of practice closer towards those of a configuration of participative practice, nurses may more likely be involved in attempting to realign the patients' practice relations towards a medical and institutional goal of acute care 'throughput' (Thatcher 1999). It seems clear that an examination of the process of utilising capacity (Hill 1978), of learning to recover, requires closer study of the contextual relations in the care setting. The insights from such a study may also pour light upon the role of the nurse in patients' education.

## **Part 7: Summary**

To investigate this topic in an appropriate manner, it was necessary to carry out a review from distinctly different areas of literature. As already pointed out (in the preamble to this chapter) there is a dearth of research which specifically focuses upon the experience of recovery from surgical intervention. As a consequence this review represents an attempt to identify areas of literature which establish a cogent knowledge base for this research.

Literature which shed lights upon the values and perspectives of health professionals was explored because of the importance of the societal context in which the study participants were patients and also interpreters and narrators of their rehabilitative experiences. The powerful influence of individualism and biomedicine were the main themes of the first part of this review.

The experience of recovery was conceptualised by the researcher as a learning process and patient education sources were discussed in relation to what it is that is learnt. This was done utilising the theories concerned with the nature of practical knowledge. A review of Lave and Wenger's perspective of socio-cultural learning theory was then undertaken in fine grained detail given the extensive use of insights from their work in the analysis of the data.

Adopting Lave and Wenger's interpretation of learning as a practice experience taking place in communities of practice, the literature which specifically addresses recovery contexts was explored. The intertwined social, emotional and relational threads of recovery were made more visible through taking this contextual perspective. Given the dearth of professional work which seeks out the patient's view of the recuperative process, the researcher looked for literary sources. It is argued that the inclusion of these sources provided added value to this literature review because literary texts contain a complex intertextuality not present in professional studies. Simultaneous multiple ways of seeing and interpreting the world of illness and recovery were evident in the work of Plath and Watt.

Finally, with a view to addressing how care professionals contribute to the patient's recovering experience, the literature pertaining to the role of nurses in patient education was explored. The inappropriateness of conceptualising patient education in terms of cognitive learning theory highlighted the relevance of Lave and Wenger's interpretation of the learning experience. The broader relational way of seeing the patients experience that this interpretation gave led to an exploration of research concerned with levels of support. From this exploration a more complex representation was developed of where nurses might be placed in the learning experience of patients.

### *Chapter 3*

## **Methodology and methods**

### **Part 1: Methodology**

#### ***Section 1: The research problem***

The purpose of this study was to explore female surgical patients' descriptions of what for them, constituted the experience of 'recovering' to health. There was also a secondary aim of finding out what might have helped or hindered post-surgical recovery. A qualitative research approach was adopted. According to Silverman (1993, p6), generating a 'researchable problem' in qualitative research involves some or all of four sorts of sensitivity: historical, political, cultural and contextual. The latter two in particular were employed in the development of this study's researchable problem. The original interest of the researcher had been to discover what surgical patients had to say about educational interventions that they may have experienced during their recovery. Utilising a contextually sensitive perspective it became clear that there were difficulties in framing the interview questions along such a line of enquiry as the study participants were unlikely to associate 'education' with being a post-surgical patient or themselves as 'learners'. In addition the imposition of an educational framework upon the patient participants' context would have been inappropriate in that participants contextualise for themselves their everyday living in a social world. The application of the researcher's assumptions as to what was a relevant context would have failed to get close to addressing the area of research interest, or at least set limits upon what could have been found out. At the same time, it was important to be clear that the qualitative research undertaken should not be aiming at garnering accounts of 'authentic' recovery experiences as 'authentic' is always culturally defined (Silverman 1993, p6). Rather what would be collected would be cultural representations of what makes for an individual recovery experience. In other words, the participant's presentation of his/her's surgical patient 'career' of recovery

would be shaped by the social and cultural world in which the 'career' and the interview has taken place. Through the accounts the values, beliefs and assumptions of that world are made accessible because the participant/patient's account is part of such a shaped experience.

### ***Section 2: Interviews***

Interviews which were taped and transcribed, were chosen as the principal method of gaining access to something of the nature of the experience of recovery as the study participants saw it. Unlike non-participant observation which would perhaps facilitate access to how the patients **behave** in a recovery situation, interviews enable the exploration of how the patients **define** their situation. Participant observation may have been a way to getting close to this defining activity. However, few researchers, including this one have the opportunity, as Roth (1963) did, to become a **participant patient**.

There has been much debate as to whether interviews can actually provide access to peoples' lived experiences. Dingwall (1997) was very critical of the use of interviews. Interviews, he argued, were 'documents of the researcher-researched relationship'. Mishler (1986) argued that the standard interview schedule functioned to 'context strip' and so hinder the participant's efforts to make sense of his/her experience. Dingwall cites Cicourel's (1964) critique of the research interview as evidence of the inadequacy of the strategy. Cicourel examined the underlying theoretical presuppositions within contemporaneous works on the use of the interview in social research. These presuppositions were to do with the ideology of naturalism. When naturalism was applied to the interview, a true picture of the interviewee's experience could only be got through ways of 'neutralising' the 'social' character of the interview. The impossibility of this was illustrated in the contradictory roles which were recommended for interviewers. The interviewer needed to be 'friendly' toward the interviewee, but at the same time not 'contaminate' the relationship with his/her own values and agendas.

Even with an unstructured question format, interviews cannot be the same as having a 'normal' conversation due to the unequal relationship between the researcher and the researched. Okely (1975, p171) argued that 'the inquisitor never abandons his dominant



role'. According to Dingwall (1997, p58) 'accounts' are the product of the inherent social instability of the interview. 'Accounts' consist of the verbal efforts, of interviewees aimed at preserving or achieving an interactional order threatened by the interview process. This is a process in which the interviewee is faced with, for example in a very unstructured format, having to work out what it is that is expected of him/her to talk about. There is an onus upon the participants to be competent in whatever role the interviewer casts them. He/she needs to work out what that role may be as well as that of the interviewer's. Something of this activity was identified by Jorgenson (1991) in her study about how families define the concept of 'family'. She argued that a process of negotiation took place between interviewer and interviewee in terms of the descriptions of what 'family' meant. According to Jorgenson (1991), the descriptive outcome of such negotiative work depended upon 'how they (interviewer and interviewee) come to interpret each other as social actors' (Jorgenson 1991p215). Her interviewees used a range of interpretations to make sense of her identity during the interviews. At different points in the interview the participants communicated that she was a research psychologist or alternatively, that she was a family expert on the basis that she was a family member herself. It is suggested that in this study, the participants, when asked to address such concepts as 'health' and 'recovery' in an interview situation also sought to achieve some sort of stability in the relations between themselves and the interviewer. As the researcher had not overly emphasised her health professional background to the participants, preferring to introduce herself as a 'research student', there was a tendency on the part of interviewer and interviewee to adopt functional perspectives on health, illness and recovery widely shared within Scottish society. It could be conjectured that participant definitions of recovery to do with self-responsibility, 'not lying down to it' and 'tholing' were 'competency presentations' to someone they knew so little about. Apart from living in the same culture, there were several other, more specific identities conferred upon the researcher. Some participants for example, conferred a formal evaluative role upon the researcher. That this was the case was illustrated by the participant who sought to present some of her unsuccessful surgical recovery as down to a premature hospital discharge. Another conferred identity was 'nurse' in that in some accounts there was an assumption of interviewer knowledge to do with the routines of hospital life as well as wound healing (a good proportion of

participants' wounds were shown, unasked, to the researcher). Jorgenson (1991) saw this 'reciprocal perspective-taking' by study participants as occurring to deal with what was not an everyday question. In addition, attempting to answer health related questions is never a neutral activity (Cornwell 1984 ). The participants of this study therefore could be seen as having to grapple with questions about their health and recovery and seeking out motives and the purpose of the research. This activity necessarily involved conferring particular identities upon the researcher.

Burgess (1984) called interviews 'conversations with a purpose'. This was corroborated by the researcher who, as the study interviews proceeded, found that she did not have a monopoly upon purposefulness. Oakley (1981) argued that from her experience of interviewing women, talking with a purpose 'woman to woman' was not a one-way process. She reviewed the literature on interview technique and, using her longitudinal research study of women experiencing childbirth and motherhood, pointed to a lack of 'fit' between these texts which advocated the objectifying of the volunteer and situations of great personal moment for the interviewees which she had asked about and at times actively shared in. Interviewees in this study asked questions of the researcher as they had in Oakley's work, and the researcher felt the necessity not to give some sort of neutral answer, but for example, an encouraging response - the kind of response that maintains the sense of context that the interviewee has adopted. Such a response has to be about acknowledging that the interviewer and interviewee have backgrounds and values which must shape any communication. On reflection and from the several readings of the transcriptions, the researcher may have some of the time practised what Mishler (1986, p130) called 'conscious partiality' and at other times have been attempting a 'professionally neutral' approach.

It was argued by Dingwall (1997) that 'naturally' occurring data gathered through observation was more likely to reflect the 'truth' than interviewing. In comparing the two methods, he noted that 'interviewers **construct** data, observers **find** it' (Dingwall 1997, p 60). However, Silverman (1993) suggested that neither sort of data was superior to the other because what really mattered was how the research findings were analysed. As regards the form of the analysis of interview data, Silverman (1993) argued that what was important was to make clear what sort of 'truth' was being investigated, whether it was

'facts' to do with the external reality or whether it was to do with the function of the interview as a social event. In this study the interview transcriptions were viewed in tandem as potential sources of 'facts' and as 'displays' and representations of moral behaviour (Baruch 1981). Dingwall (1997) although very critical of the interview as a research tool did concede that the external reality of the participant could be 'glimpsed' in accounts of his/her experience. However, the problem with this was again to do with what the researcher would see or choose to see within interview transcriptions. Reissman (1993, p10) portrayed the research process as 'levels of representation' which began with the selective 'attending' by the researcher to what is before her through to the 'reading' level when the final audience is in contact with the work and brings to it their own set of values and theoretical constructs. In this study, one strategy adopted to reduce the chance of this happening was the exploration of deviant cases in the data ( Silverman 1993; Hammersley and Atkinson 1995). This activity not only ensures that more than one form of 'reading' takes place but can result in some interesting new lines of thought about the data as a whole. An example in this study of how 'deviant' cases can provoke further reflection was through the examination of an 'atrocious' story (Dingwall 1977) from Participant 16 (A) in which she talks about negotiating her way out of hospital. This story threw a less positive and thought-provoking perspective upon the rules and routines of Ward A than had been elicited from the other participants. This attention to the 'deviant' case resulted in a wider and looser set of ideas concerning recovery in the sense that greater attention was paid to a greater variety of social relations that may have been experienced. Another example was the interview with Participant 8 (A) in which she made no specific mention or allusion to 'rules' of recovery. That she was the only participant from her ward group who did this, produced an alternative 'reading' of the other 'rule-equipped' accounts. Looking out for what was **not** said was another strategy in itself (Coles 1989) which was utilized in this study to limit the influence of researcher 'readings'. An example of how this may have added to the analysis was the finding that there was a relative absence of reference to individual nurses from the narrative content of most of the participants. Addressing why this was the case led to a more complex analysis of the place of nurses in the patient's experience.

### ***Section 3: 'The magician is part of the plot'.***

To make clearer the influence that the researcher's presuppositions may have had upon the research process, the researcher's perspectives and agenda and how these may have changed or developed during the work (Kenna 1992), are referred to at different points in this thesis (see pages: 68; 160-161). During the interview phase of the research the investigator had experienced the onset and slow recovery from a chronic condition and was mindful of Zola's (1991) argument for the health of the researcher to be part of the contextual picture. Hence the researcher has produced some biographical details which may assist this (see Fig 2 in this chapter). This practice was advocated by Okely (1975) in her case for the acknowledgement of the self, the personal and the subjective of fieldwork. Whyte (1943), in his study of street corner society included a biographical commentary on his pre-research background and his thoughts concerning his behaviour and place within the research process. As Hastrup (1992, 118) argued, 'the magician is part of the plot'. The goal in providing such contextual details was to 'inform' the analysis but at the same time not upstage it (Cohen 1992, p230). Provision of personal contextual details enables the author of the text, the researcher, to be included in the research context and so should make clearer the possibility of other interpretations. The greater the contextual detail, the more likely that the reader could be persuaded that there may be something of relevance to other patient recovery situations.

### ***Section 4: Giving further context***

Some pre- and post-interview notes were made and presented with the transcripts with the aim of maximising the 'situatedness' of the interviews. These notes added some contextual details about the research participants, including the researcher, at the time at which the interviews took place. For example, the second interview with Participant 10 (A) took place in her parents' home and with her mother present at the interview. A detail such as this assists in giving the reader access to the contextual relations of which the interview becomes a part. The researcher's notes included her thoughts concerning her relations with the participant before and after the interview and were aimed at providing further transparency and avenues for the interpretation of the accounts.

Hammersley and Atkinson (1995) examined what they saw as one of the most important aspects of context, that is, who is the audience that the answers or accounts are being directed at. Most obviously the interviewer was audience. How the interviewees saw the interviewer, as well as how they conceptualised the research and the research goals, may have had a 'strong influence' on what they said. It was also possible that a more public audience was addressed through some of the accounts. This was quite likely in this study as the volunteers were informed prior to consent being obtained that there may be work published from the research. In addition to this, there were some strong indications in what was said that they expected something of the findings to be passed on to the health professionals in a more direct form. Such expectations may have been related to the accepted position on the process and benefits of research in Western culture (Bowler 1997). Notes were made by the researcher about what was said or done off tape before and after the interview 'proper', with the purpose of further contextualisation of the interview process (Reissman 1993). Most of the second sessions with the participants involved quite lengthy conversations off tape after the interview and these conversations happened because they were perceived to be separate and truly 'off the record' and as such, will not be exploited in any detailed way, but only referred to, to help with this need to give context.

A further aspect of contextualisation relates to the issue of generalisability. In the quantitative research tradition generalisability is to do with the applicability, for example, of the sample characteristics, settings and measurement variables to other research. Qualitative workers have modified this idea of generalisability to one described by Guba and Lincoln (in Schofield 1991) as 'fittingness'. From this perspective the process of assessing generalisability focuses upon the degree to which the context studied matches other situations that the reader of the study is interested in. For such a process to be achieved it is important to provide 'thick' descriptions of the research so as to enable assessment as to its applicability to other situations. This is done by providing 'comparability' and 'translatability'. The former refers to the extent to which the various parts of a research study, for example, concepts, sample characteristics and settings, are described well enough to enable other researchers to use the results of the study as a basis for comparison (Goetz and Le Compte 1994 in Schofield 1991). Translatability refers to

the degree of 'thick' description of the research methods and the theories applied. A test then of the generalisability of this study would be for some future research work to use the findings as a 'working hypothesis' of what might occur within a later researched situation.

### ***Section 5: Ethical considerations***

As the study centred upon the accounts patients gave of their hospital and home recovery experience, it was likely that they would touch upon aspects of themselves which belonged to their private personal and social world. It was necessary to ensure that their right to privacy was respected and at the same time seek to learn more about the social experience of surgery and make this learning accessible to others. It is hoped that these apparently contradictory intentions were met by the researcher. The moral frameworks used to explore this contradiction or tension within research activity, were based upon both deontological and consequential ethical principles. From a deontological perspective, judgements as to the morality of the research were based upon specific universal principles irrespective of the context in which the researcher may find herself. A consequential perspective was also employed as this is concerned with the context and the consequences of research activity (May 1993). According to Bok (1984), rather than considering whether the study's subject area is morally correct to study, which, he argued, would result in the trivialising of social research, the investigator should attend to the processes by which data would be obtained.

Applying the deontological principle of respect for persons to the processes of this study involved respecting the study participant's ability to make decisions that were right for them given that they were presented with all the relevant information, an assurance of anonymity, and that they were deemed competent to be approached (Bok 1984). Three issues arose from this in relation to this work. The first one was to do with how 'informed' consent is, in the sense that a decision has been made for the participant by the researcher as to what is 'relevant'. From the researcher's perspective, it had to be made clear to the participants how their data would be disseminated and of their right to withdraw from the consent agreement at any time (Scottish Office 1992). At the same time the researcher had to be less forthcoming in relation to parts of her agenda because making all of it accessible to the participant may have skewed and narrowed the focus of the study. In this



study, to have been totally open about the educational interest of the research would have most likely resulted in interviews dominated by the attempts of the participants to address this interest. As a consequence, there would have been less focus upon the recovery process and how the educational was positioned in relation to it. A consequential or 'ends justify means' ethical perspective was taken in that instance.

The second issue of pertinence to this study was that of competence. The selection of the study participants had an ethical component. On being observed or approached by the researcher, a number of potential 'recruits' who had, on paper, appeared to 'fit' the selection criteria, were either deemed not able to make decisions as to what was right for them or were too physically overburdened to be included (see Fig 1). Ensuring anonymity, the third issue, could theoretically, have been a difficulty in that, according to Punch (1986), the anonymised location of the research could be easily identified by looking at the academic institution that the researcher was attached to. In practice, however, given the lengthy time span between data collection and any publications associated with the work, the danger of breached confidentiality was very unlikely. An instance of when the confidentiality of the individual participant's responses would have been renegotiated with her was if a major negligence of care had been uncovered by them (U.K.C.C 1984). Fortunately, this did not happen in this work.

### ***Section 6: Generating narrative***

The question format chosen for the first and second interviews consisted of an aide-memoire of topics with several associated questions which could be asked if the topic was not raised spontaneously by the participants (see Appendix I). In designing this format the researcher had to decide what it was she wanted to find out about, what kind of answers were wanted and how these answers would provide 'glimpses' of the participants' experiences of recovery (Dillon 1990, p168). This activity generated the topic 'headings' and from each of these, three to four questions were devised with the aim of generating narrative. These questions were designed to be used only to focus upon a particular topic if the participants had not talked in relation to it spontaneously. As already noted, answering questions and talking about one's health or illness is not a neutral, easy activity (Cornwell 1984; Crawford 1993). According to Askham (1982), stories may be told as a

means to deal with difficult questions. The encouragement of story-telling was aimed at facilitating answers which would impinge in some way upon the focus of the study. To promote narrative the questions were open and some invited a story to be told by, for example, asking for a description of a particular episode in the recovery experience or the simple 'How did it go?'. Further facilitation of narrative came through helping participants with their memory of what they had said in the first interview through linking to a post-discharge question ('You said before your operation that --- would be a sign of getting better, what do you think now?'). Whether due to the question format or otherwise, the researcher rarely had recourse to many of these questions as the participants tended to have addressed them themselves in their accounts.

The sort of narrative that was generated was sense-making or reflective in character. According to Mishler (1986) reflective narrative from interviewees was more likely to be generated when the relationship between the researcher and the study participant has been one in which the latter had been empowered to 'give voice' to the contexts of meaning that the questions provoke. Mischler argued that the 'predetermined scheme of relevances' of the standard interview schedule had a similar effect as the 'identity-stripping' process of institutionalisation. In other words, the interview questions from such schedules were a negative experience for respondents. The result of this was respondent alienation due to the lack of personal contextual meaning attached to the questions or expected of the answers. Given the relatively large proportion of narrative within the participants' answers in this study, the researcher suggests that overall, the aide-memoire of questions was quite an effective research tool. It could also be argued that this effectiveness in facilitating contextual meaning was why there were modifications undertaken to the original questions. An illustration of this was a question from the first interviews which was dropped after four interviews ('When did you find out you were coming for surgery?'). The intention of the researcher had been to garner some data as to the patient's experience of realising surgery was imminent. Instead the participants addressed the question with long stories to do with the vagaries of being on an N.H.S. waiting-list. From Mischler's perspective the participants were 'empowered' enough to approach this question from where they thought the meaning of the question lay. On reflection, the researcher's decision to delete this question due to the time limitations of the ward-based

interviews was a mistake given the possibilities the question provided to enhance a view of the social context in which the interview took place, including the interviewee's construction of it.

In this study some details of tone of voice and gesture have been included in the original typed transcripts (Briggs 1886). To further assist with this approach, notes generated from a primary aural 'read' of the tapes were made. By directly listening to the tapes such characteristics as presentation; plot development; dramatic sequences; the level of enthusiasm etc., were identified (Coles 1989). The interviewer's part in the interview, her questions and responses have been included in the transcriptions so as to enable a clearer picture to be drawn of her role in the interactional production of the narrative within the participants' accounts (Reissman 1993).

### ***Section 7: Narrative analysis***

It was anticipated that 'glimpses' of the 'facts' and social and cultural representations of recovery would be contained in the participants' accounts in the form of narrative. The researcher posited that as the nature of narrativising is to organise experiences through time, narrative analysis was an appropriate approach to getting close to how the participants represent their experience as a process (Ricoeur 1984 in Hydén(1997). Hammersley and Atkinson (1995) pointed out that it is not only what is said before and after but where the participant places her actions in time. Taking cognisance of time within the participants' narratives was to result in an interesting difference between the two groups of participants concerning the sort of time conceptualised as marking the process of recovery.

The researcher worked with the view that the analysis of the participant's talk must be centred upon the function that different kinds of talk perform in the particular context of each interview. Silverman (1993, p209), advises that the researcher ask 'when does such (motive) talk get done, what motives are available and what work does 'motive talk' do in the context in which it arises'. Briggs (1986) reflecting upon what he had seen as fruitless conversations that he had had with an old Mexican couple had found that his goals for the interaction had not been theirs. As a younger person asking questions about their

community, the elderly couple had taken the line that he was a novice and they as elders, were the teachers and as they saw it certain aspects of the community had to be learnt first. What motives may underlie participant talk is perhaps most fully elucidated by identifying the function of the narrative within talk. Hydén (1997, p55), examining 'illness narrative' posited that it has five functions: 'to transform illness events and construct a world of illness; to reconstruct one's life history in the event of a chronic illness; to explain and understand the illness; as a form of strategic interaction in order to assert or project one's identity; to transform illness from an individual to a collective phenomenon'.

Hydén's theory of illness narrative provided some elaboration as to the kinds of function that may be served by the narrative content to do with the recovering experience. Whenever people are asked about health or illness their answers are not just about their physical condition but are accounts which seek to construct a place for themselves in the everyday social world of relationships and responsibilities (Radley and Billig 1996; Backett 1992). The participants' accounts about their recovery from illness to some sort of healthier state were expected to yield a complex set of ideas that reflected the social discourses of the society in which they interacted. Bruner (1991, p5), described narratives as not only representing but 'constituting' reality. By this he meant that culture can be accessed through narrative in that 'cultural products' such as language mediate thought and so colour representations of reality. Bruner attributes this concept to Vygotsky's theory that the individual's inner private consciousness has some of the characteristics of social interaction. From this perspective narrative described by Bruner (1991, p6) as 'an instrument of mind in the construction of reality' could provide some sense of the 'reality' of recovery as a social and cultural experience. Hydén (1997), focusing upon the narrative within talk, argued that the analysis of illness narrative has focused increasingly upon recognising that the nature of the talk is dependent upon the context in which it is presented. Narrative production, as an activity, functions as a way of weaving together the experience recounted with the personal biography, the everyday life events and their meanings for the narrator.

Recovering from surgical interventions is likely to provide many opportunities for narrative-making given the unique place this state of being must have in human experience. Having surgery requires a formal, legal consent process in which the individual chooses to

place herself under the knife of the surgeon and chooses to undergo anaesthesia which results in some form of dependency. Not infrequently, the prospective surgical patient does not 'feel ill'. Surgical intervention results in an immediate deterioration in health and 'recovery' is a process which involves overcoming the physical 'damage' done with the patient's permission. Sometimes it is a process complicated by the continuing ill-health which precipitated the surgery. Much narrativizing then was likely to be undertaken to describe events and mull over decisions taken, presenting how recovery is being managed, the problems experienced and 'lay' theorising as to why they are being experienced.

A possible analytical aid is Hydén's classification of the types of illness narrative based upon the relationships between the illness, the narrator and the narrative. Hydén called these : illness as narrative, narrative about illness and narrative as illness. (Hydén 1997, p54). Illness as narrative is the expression of the illness experience, of anxieties, pain, uncertainty and how the individual feels, thinks and acts to deal with being ill. Narrative about illness delivers the informational form of talk which contains descriptions of the events involved and views and theories concerning them. Narrative as illness involves talk that is an expression or sign of illness. Given the characteristics of the surgical experience already presented, fear, distress and post-surgical 'blues' may be constituted in this third form of illness narrative.

The researcher's approach to the analysis of narratives was to begin with a clear definition of narrative and what can be learnt about the reality of recovering from surgery through narrative analysis. Brunner (1991, p4) argued that people organise their experience and memory of happenings mainly in the form of narrative-stories, myths, justifications etc and that 'narrative is a conventional form, transmitted culturally and constrained by each individual's level of mastery'. As such it is only possible to achieve a 'versimilitude' to the 'real' world. According to Reissman (1993, p22) 'Narratives are interpretive and in turn require interpretation. They do not 'speak for themselves' or 'provide direct access to other times, places, or cultures (quoting Stivers 1993). Our analytic interpretations are partial, alternative truths that aim for 'believability, not certitude, for enlargement of understanding rather than control'.

The notion of mastery is of pertinence to an analysis of narrative in that according to Bruner (1991), through the processes of 'narrative necessity' or 'narrative banalization' the listener may be tempted to take the story 'as it is' and fail to make an interpretation of what is being said. The former process could result when a story is told so well that to the listener there seems to be no other interpretation that can be made. With 'narrative banalisation' in which the narrative is so conventional or predictable, there can be the tendency by listeners to resort to an automatic interpretation of it. Again to avoid such automatic interpretations it is important to take notice of why and when a story is told and to have taken cognisance of how the speaker and the listener interprets each other's background (Silverman 1993; Bruner 1991).

How does one recognise narrative was a further issue for the researcher. 'Wellformedness', Askham's (1982, p553) defining characteristic of a story seemed helpful. This to Askham entailed, 'the recounting of two related events in temporal sequence together with some element of a finale' (Askham 1982,p554). Recognisably complete stories or vignettes were found in the data and there was a good deal of narrative particularly from the Ward A participants which was strongly chronological in character. However, Askam's definition seemed less helpful in describing the 'story lines' which would appear at different points in the interview. Disjointed narrative was described as 'episodic' by Reissman (1993, p17), who argued that sequential narrative with a recognisable beginning, middle and end was a social construct of 'Western, white, middle-class interviewers'. Episodic narrative is thematic as opposed to chronological. Apart from possible social class differences in how narrative is organised, the semi-structured qualitative social research interview can cause disjointedness so making the task of locating narrative difficult. Goffman (1981), noted that the choice of what portion of the 'talk' to focus one's analysis upon had not been settled. He argued that the 'substantive unit' for analysis could not be easily separated from other portions of the talk because each part tends to be linked to another. He seemed to be acknowledging the existence of episodic narrative when he recommended 'cross-sectional analysis' and 'examining moments of talk' (Goffman 1981, p131). Apart from examining the transcription for themes and temporal characteristics, another aid for recognising and understanding narrative was Bruner's (1991, pp6-19) identification of ten features of narrative. For example, he



identified 'particularity', as the use of particular sorts of happenings as a vehicle to achieve 'suggestiveness'. This narrative feature was evident in the study transcriptions in the form of the 'first walks' of the orthopaedic participants which the researcher will argue later, created a sense of what could be termed the 'supportive abandonment' that they experienced from the care staff. The process of coming to such interpretative conclusions involved listening to the taped transcript and many readings of the written transcripts and from these activities similarities in narrative structure and content emerged. This process was also aided by being able to contrast the transcriptions of one patient group with another. This proved to be a fruitful exercise because it provoked questions about why some sorts of narrative or content were common to both groups and some were not. Why a particular pattern of stories should be present in one set of transcriptions and not in the other makes for potentially interesting explanations. Explanations which were more likely to take understanding of recovery further than an analysis that took what the participants said at a descriptive level only. Differences that were discovered between the sets of transcriptions also served to provoke further consideration of the differences of contextual detail between the two groups of patients. An illustration of this was the difference in the referral by participants to other patients within the ward. This difference prompted further thought as to the possible pertinence of relations between patients recovering from surgery. As mentioned earlier, attention was paid to 'deviant' accounts and narratives on the basis that something else would be learnt about the nature of the recovery experience. In the context of this study what was meant by 'deviant' were those accounts and narratives which stood out in some way from all the rest. Hammersley and Atkinson (1995, p236) quote Bateson's view of the need to 'Treasure your exceptions' as a necessary element of the process of analytic induction. Examples of such exceptions in this study were the 'atrocious stories' found in some of the accounts.

'Atrocious story' is the term devised by Dingwall (1977, p393) to reflect 'the dramatic character of the account by which a straightforward complaint or slight is transformed into a moral tale inviting all right thinking persons (the audience) to testify to the worth of the teller as against the failings of the other characters in the story'

It seemed to the researcher that apart from the specific complaint or dissatisfaction expressed, the narrative effort involved in producing the 'moral tale' provided opportunities

to ‘glimpse’ something else of the recovery experience. An example of this was a lengthy story of post-discharge complications and professional neglect in which an insight was given into the way the rules of recovery laid down by the professionals may be ‘worked’ by the patients to obtain a premature discharge (Participant 16) (A).

### ***Section 8: Validity***

‘Trustworthiness’ rather than ‘truth’ has been adopted as the more appropriate way to determine the validity of the interpretations made in this study, given the social character of accounts (Reissman 1993). Riessman (1993) cited four criteria which may be utilised in establishing trustworthiness: correspondence; persuasiveness; coherence and pragmatic use. Correspondence, the showing of research findings to the study participants was perhaps the least useful for validation of this study’s findings because the participants’ perspectives were likely to change since the time of the interviews and therefore they would be less likely to concur with them. An examination of Reissman’s other criteria will be done in relation to the task of evaluating this study. Discussing the ‘paralysing’ influence of post-modernism and phenomenology upon the analysis of interview data, Melia (1997) argued for the production of ‘plausible stories’ which would contribute something to one’s knowledge of the social world. There are difficulties with the persuasiveness of interpretations in that there is a danger that what is being evaluated is how well the work has been written. To avoid this it has been argued that there needs to be a well supported theoretical argument. The evidence produced in support is particularly persuasive when it originates in the narrative. Persuasiveness may also be enhanced if other interpretations of the data have been carried out (Hammersley and Atkinson 1995; Reissman 1993). These measures were attempted in this study. Lave and Wenger’s (1991) sociocultural situated learning theory was adopted after an initial analysis identified the theme of ‘communality’ within the Ward A accounts. Further thought upon this theme led to a closer focus upon the social relations of some sort of shared recovery. As to alternative interpretations of the data such as ‘patient work’ and ‘individual responsibility, these developed separately in the earlier stages of the analysis but then came to converge upon a new interpretation to do with representations of membership of communities of participation (Lave and Wenger 1991). In the overall design of the research the investigator sought to persuade as to the

generalisability of the work by as full a description of context as possible. Examples of this were the written compilation of participant profiles (see fig 2) and detailed descriptions of the wards. In addition the tape transcriptions were kept unedited (except for anonymity requirements), and included the interviewer's participation, so as to enable access to what came before and after the researcher-chosen excerpts. In this way it was hoped that there was a greater possibility that the reader would find the work convincing. Validation through the study being the basis for others' research, Reissman's (1993) 'pragmatic use' criterion, is not useful for present purposes. However, what can be done in relation to this criterion, is to make as visible as possible how the interpretations of the data came about and making available to others the original transcriptions and associated notes. A resume of some of the data interpretation is given below.

The original themes compiled by the researcher were: 'rules talk'; 'other patients'; 'function of the interview'; 'health discourses'; 'taking responsibility'; 'risk talk'; 'atrocities stories'; 'ward rounds'. Making comparisons between the two groups of participants, resulted in the discovery that from one group there was 'rules being adhered to' talk and in the other there was none. Further readings of the latter transcripts resulted in the additional theme of 'patient work'. Such a development was assisted by reading Strauss et al's (1985) research which identified the 'invisible' work that patients do. When the concept of 'work' entered the analytical process a further category emerged from the transcripts. This was 'rule-hunting talk'. More contrastive work to do with the 'other patients' identified a relative absence of reference to others in one set of transcripts compared to the other. This discovery prompted more thought as to the nature of the reference. The concepts of 'shared travail' and 'personal recovery theory' emerged and with them ideas to do with the sorts of relations that might generate such a sense of sharedness.

The researcher hoped that the validity of the study was also strengthened by the degree of coherence in the interpretative work of the study. In other words, that the interpretative connectedness was as 'thick' as possible between the sorts of meaning-making activity identified within the narrative. According to Agar and Hobbs (1982) (cited in Reissman 1993), there are three forms of coherence: global, local and themal. The greater 'connectedness' that there is found between these forms, the more coherent the

interpretative work. In relation to this study, there have been illustrations of all three forms. Global coherence which refers to the overall goals the speaker-participant has in telling a story, was identified by the researcher in the analysis which explored the 'accounting for' narrative in the transcripts. One participant goal that was identified in this analysis was in presenting oneself as being responsible in looking after the wound site. A connected local coherence (ie how the participant sought to communicate her goal through her narrative) was identified in for example, vignettes of participation in the ward routine (rule-following) or stories of seeking out the 'do's and don'ts' of convalescence (rule-hunting). Finally, a linked themal coherence (recurrent theme in the narratives), which related to the global and local illustrations were the 'first walk' stories which provided a thickness to the analysis and enabled further coherences to emerge from the transcripts to do with membership and learning.

In summary, the greatest limitation of this study has been the use of interviews given all the difficulties associated with them. Although there was a good deal of effort put into making visible the situated nature of these interviews and the accounts that were generated, the researcher was aware that what could be 'discovered' would provide only a 'glimpse' at the 'reality' of recovery experiences. On the other hand, because of the contrastive nature of this study, there was much in the differences of form and content within the interview narratives which provoked many more questions about the recovery experience. The differences elicited, generated the adoption of an educational theory hitherto unused in the study of recovery, and this led to further ideas and questions concerning the recovery experience. According to Lather (1986, p259), 'Truth is not one thing, or even a system. It is an increasing complexity'. The researcher posits that this study has contributed something to such a truth.

## **Part 2: Method**

At the outset of this work, the researcher sought permission for clinical access from the Director of Nursing and Quality. Permission was approved and two surgical wards were identified for the researcher to approach subject to the approval of the Research Ethics Sub-Committee of the relevant Health Board. Approval from this committee was given to proceed. Further permissions for access were sought and given at the local level of the

medical directorate, senior nurse, consultant and ward manager (see Appendix II for letter to the ward managers and Appendix III for introductory letter to selected patients).

The research consisted of taped semi-structured interviews with patient participants from two different wards (Wards A and B) in two different hospitals (Hospitals East and West). The plan was to interview each participant twice, once in hospital prior to surgery and then later two to three weeks post-discharge from hospital. Contextual or 'field notes' were to be taken after each interview. In addition, after several interviews had been carried out with the Ward A participants the researcher undertook a non-participant role at the pre-admission clinic of Hospital East. The researcher was prompted to do this because of the participants' consistent referral to their pre-admission clinic experience. The researcher sought permission to gain access to the clinic. About four hours of observation was undertaken. This entailed following the patients as they were 'processed' by a multi-disciplinary team of health professionals. The researcher took any opportunity that arose to talk to patients and staff about the pre-admission experience. Notes were made shortly after and these can be found in Appendix IV.

### ***Section 1: Sample and sampling context***

Ward A was situated within a specialist orthopaedic hospital. It had a busy operating schedule with elective surgery four days a week and five days on alternate weeks. Five consultants had patients cared for in this unit. Like the rest of the hospital, no emergency surgery was carried out from this ward. It consisted of two small Nightingale wards which segregated the sexes. One end of the wards opened out onto a communal day-room which also gave access to a concrete patio outside. At the other end the wards gave on to a service corridor and access to toilets etc. Somewhat nearer to the male ward, was situated the nurses' station - a small glass fronted office which was the only staff accommodation in the ward and when vacant it was used for interviewing the respondents. Next door there was a large echoing treatment room. This location was where most of the other pre operative interviews were done and because of the poor acoustics, the transcribing of these tapes was difficult. The ward was managed by one charge nurse with a staff of seven qualified nurses

Ward B was a surgical unit admitting both elective and emergency cases. Theatre days were all the weekdays and at the weekends there was on call status. Three consultants are attached to this unit. It consisted of one large Nightingale ward, in the middle of which there was a small nurses' station. In addition, adjoining the main ward, there were two single and one four bedded room. Although an all female surgical ward, on occasion, it had male vascular patients when the male ward was full. There was one charge nurse who was responsible for the overall management of the ward and she was assisted by 19 other staff including 12 qualified staff.

The choice of Wards A and B was from a very small number of wards which were not being redecorated, relocated or closed within the health trust that the two hospitals were part of. In addition, the choice was also curtailed given that the study sample needed to have participants who had had at least three post-operative days in hospital. In these times of shorter hospital stays, increased day surgery and weekday only wards, there were less clinical areas which fitted the contextual requirements of the study. The researcher was happy to have as much variety of participant surgical experience as possible and so did seek wards with different specialities. The intention was not to focus upon recovery from different pathologies specifically, but to deal with the participants' conditions as the contextual detail which would be included in a comparative analysis. The particular information related to the contextual features of the two wards was gathered in an ad hoc manner by the researcher as some issue raised by the research process demanded. This was done either by asking the nursing staff or other health professionals working with the patients or by researcher observation.

The most obvious procedural difference between the wards was in how patients were admitted. Ward A's patients were invited to a pre-admission clinic a week before their scheduled admission to the ward. There they were exposed to a multi-disciplinary effort to prepare them for surgery. Convalescence at home was also touched on by an occupational therapist assessment which focused upon the heights of chairs and toilet seats etc. Ward B had no such system or any other in place. Ward A patients also attended an inter-ward teaching session organised by the physiotherapists which specifically addressed 'rules' of movement for recovery at home. No formally organised structure existed for Ward B patients.



The bulk of the data for this research was gathered from thirty-one taped and two untaped interviews between the researcher and eighteen female elective surgical patients. Notes were taken after the untaped sessions, one of which was by telephone. In addition, a small collection of contextual notes relating to the participants and the autobiographical details of the researcher were also produced (see Fig 2 for an abridged version of these notes).

In choosing whom to approach for inclusion in the sample, the principal selection criteria were that the participants needed to be female patients who were likely to see the study questions as appropriate to their situation. Participants for whom questions about getting better and being healthy eventually, were most likely to be meaningful were selected. In other words those patients excluded were those for whom surgery was a palliative measure. Although all the patients were undergoing surgery for non-terminal conditions, there was still the possibility that a patient developed or was discovered to have a terminal one. To guard against distressing such patients, the researcher, when checking with the ward staff as to the date of discharge for each patient, sought confirmation concerning a positive prognosis before making arrangements for a second interview. A further criterion was if possible, to have volunteers who were staying three or more days in hospital post surgery. The rationale for this was that there was something of a convalescent recovery period in hospital to talk about. The first two participants recruited were exceptions to this last criterion. As varicose vein surgery usually involves a relatively circumscribed and predictable hospital (i.e. less than three days post-operatively in hospital) and home recovery, patients having varicose vein surgery were approached first as a way of testing out the aide-memoire. In the event, being in hospital for less than three days post-surgery did not result in these particular participants having less to say about the recovery experience in or out of hospital.

In the case of Ward B, there was a further selection consideration. A further pragmatic exclusion process took place after talking to staff or seeing the patient. This would happen on the basis that being interviewed would be too burdensome for the patient. For example, on seeing a woman, who was to undergo a carotid endarterectomy the next day, who had, on paper, seemed a likely participant, the researcher found that she was

obviously suffering quite badly from the effects of carotid occlusion by the degree of ‘absence’ about her demeanor.

In the case of Ward A, there was another limit placed upon the recruitment of participants. Another research study, part of a national project concerned with first time hip replacement patients, in which the ward was included, was being carried out which involved interviews pre-operatively and follow up at home. Liaison with the project investigator ensured that the researcher did not approach these patients. This may have resulted in older patients and those undergoing repeat reconstructions being approached. The researcher’s limited opportunities to come to the hospitals to recruit was a further contextual restriction upon the selection of participants. Figure 1 lists those patients who refused to participate in, were de-selected from or who dropped out of the study. In the main, most were obviously physically and/or mentally unable to deal with being interviewed. It was perhaps not surprising that the researcher had, at times, selection problems given the nature of the conditions suffered by the research population. Recruitment and interviewing of volunteers took place over a timescale of about sixteen months and was divided into two periods - the autumn and early winter of 1995 and the early summer and autumn of the following year with one second interview in January 1997. The extended time frame was due to the ill-health of the investigator. The 18 participants were all female aged between 30 and 80 years of age.

**Fig 1:** *Patients who refused to participate or who were de-selected when the researcher was able to see them in person for the first time and assess that research interviews would overtax and /or intrude upon a critical experience.*

1. Ward B - refused, looked tired and miserable and preoccupied.
2. Ward A - refused, 30 year old, no reason given.
3. Ward B - had a stroke on admission to the ward.
4. Ward A - very confused on admission, (infective condition of the hip). Deselected.
5. Ward A - very frail and distressed woman admitted for third hip replacement, multiple chronic conditions - asthma, high blood pressure. Researcher withdrew.
6. Ward B - for carotid endarterectomy, looked very tired and struggling to deal with her situation. Researcher withdrew.
7. Ward B - for possible limb amputation, appeared to be in a toxic confusional state. Deselected.

In Fig 2 there is a brief profile of each of these participants. The total number approached was 26 out of which 19 consented.

**Fig 2: The study participants.**

*All participants, unless specified, were interviewed a first time by the researcher in their ward in the early evening prior to the day of the operation.*

Participant 1 was 47 years old, divorced with two children, 10 and 11 years. She was a primary school teacher. Elective admission to Ward B for varicose vein surgery. Discharged home two days post-operatively and interviewed at home 12 days after the surgery.

Participant 2 was 49 years old, married with four grown up children. Elective admission to Ward B for varicose vein surgery and with previous experience of same. Discharged home two days post-operatively and interviewed at home 11 days after surgery.

Participant 3 was 60 years old, married with no family. Elective admission admitted to Ward B for carotid endarterectomy. Discharged home three days post-operatively and interviewed at home two weeks after her surgery.

Participant 4 was 64 years old, a retired nurse, married with grown children. Elective admission to Ward A for her first hip replacement. Discharged home ten days post-operatively and interviewed at home 19 days after the operation.

Participant 5 was 73 years old, a widow with three married children. A staged re-admission to Ward A for a repeat hip replacement following the failure, due to infection, of her first replacement. There was also a history of incompetence and neglect by health professionals in another hospital which led to the participant having months of unnecessary suffering. She was discharged two days post-operatively and interviewed at home 11 days after the operation.

Participant 6 was 73 years old, a widow with a supportive daughter. Admitted electively to Ward B for femoral popliteal bypass surgery. Discharged home six days after surgery and interviewed at home 16 days post-operatively. Post-discharge wound infection.

Participant 7 was 76 years old, married. Admitted electively to Ward A for a knee replacement. Discharged home twelve days post-operatively and interviewed at home five weeks after the operation.

Participant 8 was 80 years old, a widow. Had a supportive daughter and lived in sheltered housing. Admitted electively to Ward A for a third hip replacement. Discharged home ten days post-operatively and interviewed at home four weeks after the operation. No physical improvement in her condition. Went home from hospital with hospital acquired flu.

Participant 9 was 72 year old, a widow and a retired nursing auxilliary. Large supportive family. Electively admitted to Ward A for her first hip replacement. Discharged home ten days post-surgery and interviewed at home almost three months later.

Participant 10 was 30 years old a single mother with a pre-school child. Electively admitted to Ward A for a hip replacement. Very supportive parents. Discharged home two weeks after surgery and interviewed at her parents home (with her mother in attendance), four weeks post-surgery. At the time still using elbow crutches and attending the hospital for weekly physiotherapy.

Participant 11 was 75 years old, a widow. Supportive relationship with married sister and her family. An accelerated admission to Ward A due to level of pain and infirmity being experienced. Had her first hip replacement. Discharged home seven days post-operatively and interviewed at home a month after the operation.

Participant 12 was 66 years old, single, diabetic. A recent amputee. Electively admitted to Ward B for the amputation of a toe from her remaining foot. Discharged home seven days after surgery and interviewed at home six weeks post-operatively.

Participant 13 was 80 years old, married. Electively admitted to Ward B for a toe amputation. The amputation was cancelled in favour of an angioplasty which took place approximately seven days after admission. The second face-to-face interview did not take place. A brief phone call with the participant ten days after her angioplasty found her distraught and in pain and unwilling to remain in the study.

Participant 14 was 62 years old, married. Diabetic. Admitted to Ward B as a follow up to two previous emergency admissions to the hospital. For femoral –popliteal surgery. Post-operatively suffered a deep venous thrombosis. Discharged home three weeks post-operatively. No face-to-face second interview as patient too unwell and unwilling to commit to a visit. Notes taken from a half-hour telephone conversation instead.

Participant 15 was 78 years old, married. Electively admitted to Ward A for hip replacement. Discharged home a week after surgery and interviewed at home about a month post-operatively.

Participant 16 was 73 years old, married. Electively admitted to Ward A for a knee replacement. Discharged home seven days post-operatively. Wound infection developed shortly after discharge. Consequently the second interview was greatly delayed (six months after operation).

Participant 18 was 64 years old, married. Electively admitted to Ward B for a femoral-popliteal bypass graft. Very brief untaped first interview. Discharged home one week post-surgery and due to a severe wound infection post-discharge, the second interview was delayed till two months post-operatively.

Participant 19 was 58 years old, wheelchair bound and lived with her daughter and grandchild. Electively admitted to Ward B for renal angiography. Due to her poor prognosis for the surgery planned after the angiography, no further interview was sought with Participant 19.

Participant/investigator (FM) was 41 years old, married with a baby at home. She had until two years before, worked all her adult life as a nurse. After a university nursing education, she worked mostly within the National Health Service becoming a surgical ward charge nurse and then a nurse teacher. During her years as a charge nurse she had developed an interest in patient education. She had experience of implementing a research based recuperative/educational tool for ostomists. The investigator carried out this research on a part-time basis. During most of this study ill-health plagued FM's attempts to move on with the research. Taking a more positive perspective the illness experience was to be valuable in communicating with the study participants and in the interpretation of their accounts.

## ***Section 2: The interviews***

The first interviews were undertaken in hospital the day prior to the participant's surgery. They took place in the early evening just before or just after supper and always before the visiting time, which of course was the last opportunity for friends and relatives to be seen before the surgery took place. A letter of introduction was left with the ward staff to give the possible participant on admission to the ward (see Appendix III: Introductory letter to selected patients). If the patient expressed a willingness to be involved in the research, she would be approached by the investigator. Further elaboration upon the introduction details was given before the consent process was undertaken. If consent was given, the first interview would begin. Two participants consented but were unable to give the researcher a first interview. This was due to pre-surgery anxiety in one participant and the early arrival of relatives for the other.

Prior to gaining consent the researcher undertook to assure the potential participant of the confidentiality of all parts of the study. The patient was made aware that parts of the study may be published but that anonymity was assured by changing all named participant details and by undertaking to destroy all the tapes and personal information at the end of the study. Apart from seeking the patient's consent and explaining the researcher's purpose, the function of the first interview was to make contact with the patient-participant before her post-surgery experience. Given the obvious constraints upon time that are inevitable in the pre-surgery period, and the likely emotional fragility of the participants, this interview usually lasted about thirty minutes and had a little more structure than the later one. A fairly specific list of topic areas and associated questions (if required) was prepared (Bell, 1993). This interview was to do with gathering contextual data about the participant, for example, past experience as a patient; her job, her hopes and expectations concerning the surgery and recovering from it. These sorts of questions were relatively 'easy' for the participant to talk about and likely to 'break the ice' between participant and researcher. At the same time such 'routine' questions provided the researcher with a working knowledge of the patient's circumstances as she saw them and data for placing the participant's later account in context. The second interview was of longer duration, at least an hour on tape with up to another hour off-tape. With the exception of Participant

10 (A) whose interview took place in her parents' house, all the second interviews took place in the participants' own homes. As a consequence the interview was more informal. The researcher's focus was upon the experience undergone and where the participant was in the recovery process at that time. A list of key areas and some associated questions were developed (see Appendix I). The participant were also reminded of their pre-surgery thoughts and expectations. Because the time between interviews were likely to vary depending upon the surgery and the progress of the patient, it was important not to presume that the participants would remember what was said at the first interview (Moss and Goldstein 1979).

All the taped interviews were transcribed. No editing was carried out except for what was necessary to protect the anonymity of the participants. This meant that the researcher's actions within the interviews were documented. The transcriptions included some paralinguistic details so as to enable the most accurate interpretation of what was being communicated. Prior to transcribing the researcher also listened to the tapes from beginning to end and made notes concerning what else was communicated other than words such as the emotional timbre of the participant's delivery.

### ***Section 3: Analysis and interpretation.***

Through repeated listening and readings various themes emerged from the transcriptions. There were several developmental stages which led to this emergence. Initially, each transcript was examined in terms of 'structure', 'main themes within the narrative', particular phases and sentences within each interview transcript drew the researcher's attention because they were interesting and/or surprising and/or reminded the researcher of some other work. These phrases and sentences were then examined in relation to contextual details such as what the conversation or narrative had been before and what came after. As a consequence of this wide 'sweep' through the transcripts, episodic threads of narrative were discerned i.e. common meanings and themes were identified as existing in the participants' narratives at different points in the interviews. Comparisons were also made between what was said in the first and second interviews. Further comparisons were then made with what was said in what context by the other participants. From this continual comparison activity, patterns became apparent and a first round of themes was compiled. These themes when then considered in relation to each



other and to relevant literature led to a merging of those to do with particular sense-making and representations of behaviour. The development of new perspectives concerning the interpretation of the data followed. Sociocultural learning theory as interpreted by Lave and Wenger (1991) emerged as broadly the most pertinent conceptual framework in the interpretation of the emergent themes. This theory was adopted in the development of an analysis of the thematic findings. The application of Lave and Wenger's conceptual framework resulted in some further topic development. Further readings and checking of previous comparisons followed and this finally led to a narrowing down of themes (Reissman 1993).

## Chapter 4

# Portrayals of experience

In this chapter the unedited interview transcripts are examined. According to Gilbert and Mulkay (1983 in Silverman 1993) 'the goal of the analyst ..becomes that of reflecting upon the patterned character of participants' portrayals of action'. Patterns to the participants' portrayals of their recovery experience are identified and the reflective process begins.

### Part 1: Responsibility

A major theme of participants' talk was responsibility. In some form or other representations of responsibility were used in participants responses to the researcher's questions and in the spontaneous talk they initiated. The kinds of representations that were expressed will be explored. Some large extracts will be used to illustrate the strand of responsibility that is wound through the narrative. Further smaller excerpts with some contextual detail will be used within this analysis to persuade the reader.

A frequent participant display of responsibility was to do with representing the experience of surgery and recovery as something that must be endured and in a disciplined, uncomplaining and cooperative manner.

*FM Em, I think I want to ask you another question. If eh, if there was a good friend of yours was going in, to the same ward for the same operation, em, what do you think she needs to know to get through all that's involved to get back to normal*

*R I think just sort of take in your stride, don't you? It's not a particularly major operation..em..I often think the people, I know it sounds a bit naff but, the people in for hip replacements or something that's really going to be painful ( ) an everyday op, what I've had just an everyday operation where you're expected to cope with it..em that's it though it's terrible at the time, it's sore, em...and I have*

*to take a couple of aspirin in the morning, em, which I would never...I () take a lot of tablets, eh, but I've sort of given in and said, 'Well I'll take a couple today, cos it is sore..but eh...just get on with it, you've got to! ((she laughs and I join in)) I think that's the best attitude to take in..anything you do. If I was () if you've got a job to do just do it. There's **no point just sitting round saying 'We've got this to do, aah we'll need to do it' If you've got it done that's it done, you get on with something else[ just the way it is. ( 2.2 p9)(A)***

.....still addressing FM's original question...

*FM Well no, you've been talking, you've been talking about help, in different ways....*

*R You don't get help from the hospital when you get out. You get help when you're in and they do the job well, but when you come out, there's nought, eh, nothing, I mean you're not even given painkillers. Just go home and get on as well as you can ()*

*FM You're six month appointment...*

*R Your six months appointment, but that's all, but I mean they say any problem, go to your doctor or come back*

*FM Yes*

*R So it's up to you to judge whether you have a problem [or not, em...*

*FM [Right....but that is not a problem for you?*

*R Not a problem for me, because if I've got a problem, eh, well I just phoned up the GP this morning...*

*FM Sometimes people have a difiuculty in saying, ' Do I want to phone the doctor about this?'*

*R Yeh, but people many people think far too much about things If you want to do it, you do it and if you don't you don't eh people..((interviewer laughs a little)) You know you find it's brainy people, think too much about things. I was told this by a very brainy guy once ((interviewer laughs)) he said, 'You're very lucky', he says, ' to have no brains' he says, ((interviewer laughs)) 'brainy people think far too much about things instead of maybe going on their instinct or.. you know..[I mean it's my instinct,if my leg is sore,*

*FM [Mmmm*

*R instinctively I would say, I don't really want to go to the doctor but I'll get it checked out just to be safe, em...you can switch the machine off now ((both interviewee and interviewer laugh)) 2.2 p10.(A)*

As already noted, Williams (1993) argued that the ideology of individualism can be found within narrative concerned with health and illness. Such an ideology provides a set of ideas as to how to explain, for example, ill-health as something that the sufferer is in some way responsible for. In a society where individualism is historically embedded, illness is viewed as a sign of moral weakness. Rheumatoid arthritic sufferers interviewed by Williams sought to represent themselves as in control of their everyday lives, as independent in the face of severe physical dependence. The stoicism represented by the RA sufferers is echoed by Participant 2 (B) who advises 'taking it in one's stride' and sought to play down her situation by comparing her varicose vein surgery with the more 'major' hip replacement surgery. She does talk about her pain but only to steer promptly a stoic's course 'just get on with it you've got to!'

Later she continues her 'no fuss' stance by theorising about the need for an 'instinctive' as opposed to an intellectual perspective concerning health matters. Finally, after displaying individual responsibility as a principle to live up to or an attitude of mind by which she lived her life, Participant 2 (B), it could be argued, abdicated responsibility through self control with her 'instinct' theory. It may be that this is a particular display of moral behaviour, one which seems to seek to portray an intention to be strong but because the body is weak and needs to be 'checked', an action in this instance, which is at the same time a right-minded and responsible thing to do. Perhaps this narrative could be seen as providing an illustration of a shift between two sorts of responsibility displays and so giving an insight as to the 'repertoire' (Gilbert and Mulkay 1983) of possible positions that signify 'responsibility'.

Another interpretation of the content of Participant 2's (B) talk may be developed from the idea that not only do people's health accounts reflect the cultural mores concerning health and individualism but also that Participant 2's (B) accounting for her decision to consult her doctor during her recuperation was also an opportunity to **contest** other contemporary modes of addressing the question of decisions about health (Crawford, 1993). The theorising over 'instinct' was introduced as a more suitable

behaviour to ‘think(ing) far too much about things’ . Her contribution to the interviews as events was one that was, at times, slightly questioning of the validity of what her experience may contribute to the research. The advocacy of little fuss or ‘getting on with it’ may have been a challenge to current social representations of health and illness in which the social and the psychological are highlighted (e.g. television real life series in hospital settings, documentaries). Participant 4 (A) too, in theorising as to the proper ‘attitude’ to adopt for a speedier recovery says, ‘...if you want to make a meal of being ill, then you won’t be out in ten days...’ (4.2p10). This may have been a stoic echoing of Participant 2’s anti-intellectual challenge. Participant 4 (A) had also, before her surgery, been dismissive of thinking ‘a lot into things’ and instead displayed what could be described as a personal pep talk which centres upon her fears concerning the anaesthetic. Four participants spontaneously introduced the subject of anaesthesia and it is perhaps one of a set of socially expected and accepted topics which patients can ‘safely’ discuss. Perhaps having an anaesthetic of some kind is what distinguishes surgery as an experience from other contacts with the medical world and talking about it has become a conventional or acceptable a way of expressing less ‘responsible’ thoughts or feelings related to having an operation. It may also represent the principal part of a lay knowledge base which is scanty on detail of the experience of surgery.

Participant 1 (B), in the second interview, described at length her attempts to make quite sure that she had a general as opposed to an epidural anaesthetic-using words from a popular television comedy- ‘No, I just want to be knocked out, you know, ‘Absolutely fabulous’?- total sensory deprivation and back up drugs and whatever, that’s it’(1.2. p6). Within the same talk she presented a story of her cotimeous and as it turned out, failed attempts to see a surgeon on the eve of her operation (1.2. pgs5-7). Participant 3 (B), who has never had surgery before attributes her ‘dosiness’ on going home, to the anaesthetic. Participant 7 (A) too, when trying to make sense of why she took longer than she thought to get over her previous surgery, mooted the anaesthetic as the cause (7.1.p5 ).

Participant 4 (A) had been talking about her fears that the recovery process was about to age her as she has image problems with using a zimmer:

*R ...you know, as I say, it could be sheer vanity on my part wondering how long  
I’m going to be walking about with two sticks, emm*

FM *That's really what worries you that....*

R *It worries me that getting around, not so much that I've got two sticks, just, getting around*

FM *Mm hmm*

R *Getting around your own home*

FM *((interrupts)) Afterwards*

R..you know

FM *Mm hm*

R *Emm, how much are you going to be able to do or should I say how little you're going to be able to do, that worries me. Amm*

FM *Do you feel that, do you think you are going to be like that for a while or is it....*

R *I don't know, maybe if I knew for certain, it wouldn't worry me so much*

FM *Mmmm, so you can...*

R *If somebody could say to me, 'Right, it's going to be six weeks, and then you can do all the things you've been doing without any pain. But it's not knowing how long because everyone is different*

FM *Yes, has nobody given you some sort of gauge, you know just to...?*

R *No, I don't think anybody can because as I say as everybody is different and I think a lot is your own attitude am, sort of mind over matter, your own determination...how well you get over it 4.1 p2 (A)*

R..... *As for feeling, recovering, the staff in that ward couldn't do enough, very helpful ahh, reassuring which I found you needed quite a bit of when you first got on your feet am, I was bit frightened to put any weight on my foot at all. Physiotherapists, ahh, although not greatly loved, were very necessary ((gives a little laugh)) you know am, I think, you know, you realise it's for your own good and you moan at them and you complain but without them I wouldn't have been home in ten days as I was. Amm, as for getting home ar **I think recovery has a lot to do with your own attitude, am.** I had made up my mind that, I would be home as soon as possible and there was one lady got out 10 days after her op and I thought, well, if she can do it, I can do it. And I had just made my mind up that 10 days was my target for getting home and worked at it that way. 4.2 p8(A)*



Being responsible did not equate with being overly concerned with the more cosmetic aspects of wellbeing and Participant 4 (A) took a self deprecating line - 'sheer vanity' - about her anxiety over having to use a zimmer walking aide. Functional health means the end of dependence upon others and in an individualistic society the individual is expected to value this and when ill, seek to regain it. Participant 4 (A) made clear that it was the degree of physical function that was the most important to her and that much of this was her responsibility through 'mind over matter'. Participant 1(B) too, revealed that the appearance of her varicosed legs was what had brought her to the surgeon, but at the same time, after some talk of the length of time she had waited for surgery:

*R It is quite a long time, but if I had been in pain I would obviously have had to make some kind of...but I was a bit relieved because I was wondering if the way things are going all the cutbacks if in fact I was going to be told they were not doing such things any more or something*

*FM Minor surgery*

*R Well it is I suppose*

*FM Relatively*

*R Relatively, it's not a health....well it can become so, I mean it obviously needs to be done but there are not any risks I think with having them (1.1p1)(B)*

Participant 1 (B) hinted at a future risk of ill-health if she did not have surgery, inferring that it was more responsible to have her legs attended to. This was possibly in response to the investigator's comment which was not meant as a judgement upon Participant 1's (B) actions, merely a comment and as it turned out a clumsy one relating to the type of surgery that might be affected by 'cutbacks'. At the end of the first interview after talking of the 'irony' of having non painful veins to ending up with pain post surgery, Participant 1(B) again linked the cosmetic with more 'legitimate' justifications for having her vein surgery:

*R Although I have been told by doctors that, you know, the veins are not working properly, it's going like that so it's really not very good to have it left like that, it would be better to*

*FM This doctor is your GP?*

*R ((hesitant)) Yes, the doctor in---((previous residence)), he did say, 'Well, you're not a bad case, it certainly would need to be treated in the future,*

*because, you know, you can get ulcerated legs and stuff like that, if the veins are neglected, I mean, they don't regard it as cosmetic or they wouldn't be wasting time and money. They think it best to do it even if it's not actually painning me at the particular minute. (1.1. p3) (B)*

It is suggested in this piece of talk that the authority of the general practitioner was presented to lend weight to her justification for having the surgery done.

When people tell stories, it is usually for a reason (Askham 1982). The motive may be to make a particular point or to place the teller in a favourable light (Radley 1996). In analysing stories of function hoped for, worked for, achieved or lost what needs to be explored is why they are told. For example, Participant 4 (A) told the story of how she one day decided to attempt to do the laundry:

*R Well I can wash and dry dishes, I can cook am, I can dust, I can take the dog a walk. Yesterday I did a washing am, albeit it's an automatic machine with a tumble dryer but it took me the whole day where, because it was, a slow job putting things into the machine using this thing*

*FM Mmhm*

*R.. and taking them out*

*FM ..because you can't really get down to...*

*R...because can't really get down. Am, I find that frustrating. I get angry at myself, am, because I'm not getting things done as quickly as they should be. I'm not allowed to make beds, I'm not allowed to vacuum...as you can see the mess they're with the dog. Ahh, things that have to be taken from here upstairs, if they're small items, I put them in a carry bag and cart them up but with all the washing yesterday that have to be taken up, I had to lie on the settee until my husband came home, am, and he took it up. (4.2p7)(A)*

This story was told after the previous narrative which described the physical difficulties of the early weeks at home. The interviewer's question or more precisely, response to this narrative, resulted in the laundry story. The motive surely, was to make clear to the investigator that Participant 4 (A) was making an effort and also to illustrate that she had reached some sort of turning point for the better. The story could be seen as a display of a responsible person making an effort to pull through the recovery period. It

was another display of appropriate moral behaviour. What was being addressed from a moral perspective was whether one was for giving in and giving up the work of recovery. This echoed the accounts given by Scottish women in Blaxter and Pearson's 1982 study, who, when asked to talk about health and illness, did not address having the illness as such rather that one could be judged upon whether one 'lay down' to it or not (Blaxter 1993). Legitimising her recovery behaviour included making clear that most people were likely to have had a similar experience.

In the following excerpt the researcher had asked Participant 12 (B) about her thoughts concerning the surgery she was to have on her toe but Participant 12's (B) talk was centred upon the previous surgery which had left her with a below knee amputation:

*FM You were quite poorly then? Before....?*

*R I wasn't really poorly as such but, that was making me very poorly you know that part of the leg and the, the..I mean nothing wrong with my fee.. it's just that, there was nothing wrong with even the toes,*

*FM Aha*

*R.. it's just that a dressing went on by the nurse, the next thing the dressing came off and of course I had an ulcer from that, that's the district nurse and then em..from the surgery and then at the side of my big toe there was..she put a dressing on there and the next thing I had it..So that was how it really... otherwise I could still have had my leg I think .....*

*FM Mmhm*

*R..but it must have been under the skin*

*FM Mmhm, because of poor circulation*

*R Poor circulation, that's right yes, that's what caused it the poor circulation, right, yes (12.1p2) (B)*

and shortly afterwards as the interview was coming to an end.....

*FM Aha give it time, phone up and check, whether you've gone home. As well as going home, you're going to be alright[.you're organised alright*

*R [That's right..... Oh I'm organised, well this is it, ee um I hope that won't make any difference. The only difference is that I'll have to get a shoe that's going to[. be*

FM [Mm

*R...comfortable you know, and things like that. I've always had, which I thought, paid a lot of money for shoes but it's made no difference to me . But eh, that's what I'll have to do, that's why I'm in a slipper the now, because that keeps it eh..thingwae..*

FM Comfortable

R Comfortable, aha (12.1 p3) (B)

FM So you've got three toes there, and you're managing....?

*R That's right I'm managing with three that's right. I'm worried about the third one now ((laughs)) Na I'm no really. Ehh but anyway that's how that happened so quick well it didn't happen that quickly I was getting attention from the district nurse but I think it was the dressing went on, you know, I shouldn't say that right enough, but, anyway it finished up that.. it had to, I had to go in and see them*

FM Mmhm

R..and have it off

FM Mmhm ( 12.2 p6) (B)

*R See that's why I've got this shoe because that was the only shoe I had in the hospital.. and...and I didn't know, I..being honest, I didn't know what I was going through after got off part of the leg I mean it's down to me right enough, but part of the leg gone. I didn't know what I was going through I didn't even know when at ---(( rehabilitative centre)), nobody told me anything and when the physiotherapist said to me, eh, it's at that scientific place at -----((names the rehabilitation centre she was sent to)) you know that I go to, ....physio, ehh..but anyway[ em, she (12.2 p12)(B)*

Most of both interviews with Participant 12 (B) were dominated by her talking about her previous experience of surgery to amputate her leg below the knee. This surgery had happened about nine months prior to the first interview. The talk within these interviews seemed to illustrate what Pinder (1992 p3) described as 'experiential incoherence' in patients who had been told of their diagnosis of Parkinson's disease. By this was meant that there is a time after being told what is wrong with them that people with such a diagnosis, grapple with the enormity of the knowledge . The incoherence relates to the

complexity of feelings that denote a life crisis- a 'transition from a past that might be perceived as 'normal' to a future over which hung an ominous shadow' (Pinder 1992, p13). Even before consent was obtained, Participant 12 (B) was talking about her experience of losing her leg. The impression she gave was that she was still locked into that period in her life. Perhaps this was to be expected as there she was, having further amputation surgery, this time for a second toe from her remaining foot. The interviewer sensed real fear over the future in Participant 12's (B) talk. There were lengthy periods during the conversation that consisted of 12 (B) switching back and forth over the possible causes of her having to have the previous and the present surgery. This resembled what Blaxter (1993) described as 'chains of cause' but not in the sense that her sample of Scottish women had used this form of talk. Blaxter described her participants as reaching into their pasts for specific events mainly to do with their female roles eg child-bearing, which were considered as the original causes of their ill-health. From the content of Participant 12's (B) talk, finding the cause of her current health situation was to do with apportioning blame. Responsibility was represented in an ambivalent fashion. A good deal of what Participant 12 (B) had to say could be described as 'post-mortem talk'. This was characterized by a series of episodic vignettes centred upon the previous surgery to amputate her leg. In the story-telling she directly or through innuendo laid blame upon the district nurse's dressing technique or upon her GP's lack of conscientiousness. Interestingly, she only mentioned her diabetes once to dismiss it as the cause of her vascular troubles and in the context of next laying blame upon the district nurse's dressing of her leg (12.2p6). Further sense-making activity included pondering as to whether a further vascular outpatients appointment would have picked up her problem earlier (12.2p14). However, whatever the accusation, it was always a tentative one and was withdrawn quickly possibly because of the interviewer's too careful neutrality in responding to this. In addition, the act of placing responsibility elsewhere for one's woes has to be balanced with how the individual has sought to present her responsible behaviour for her own well-being. Self responsibility in Participant 12's (B) case mainly took the form of the 'shoe story' which was developed within both interviews and was a series of descriptions of her efforts to look after her feet.

An ambivalence in the placing of responsibility for the recovery process is to be found in five of the other sets of interviews (Participants 1, 5, 6, 8, 16) (B, A, B, A, A) Like Participant 12 (B), Participants 5, 6, 8 and 16 (A, B, A, and A) had surgical

experiences in which something went wrong and the recovery process became a period of pain and anxiety. Participant 5 (A), had a lengthy story to tell of health professionals' failure to listen to her complaints of pain during her first post-hip replacement recovery and her subsequent admission to Ward A for further corrective and repeat surgery. The excerpt below was taken from the last part of her story.

*FM So you had a few months of ..pain*

*R if they had..they didn't give an x-ray between, from the operation until the doctor, she got one, now that was months if I had got it before they could have stopped it going on too long. But eh, I mean I wasn't angry with them, I mean it doesn't matter give me two feet on the floor, now that's all I want (she laughs) you know there's no, I don't want to, I don't want to see any of them, get on to them or anything,*

*FM No*

*R... not be angry about it, all I want is two feet on the floor.....hopefully, tomorrow ((laughs)) (5.1. p2) (A)*

This was 'her story', and was a vehicle for Participant 5 (A) to put herself in context at the very beginning of the interview as someone with a surgical history and that this has bearing upon what she will have to say in response to the first question 'What were your feelings....?' In the telling she specifically said that she was not angry with the professionals and that she had a 'get well' goal in mind. This may have been motivated by a concern not to portray herself as a complainer or trouble-maker but as someone who would be actively seeking health in a 'healthy' independence. Attributing a failure in responsibility by health professionals during her previous recovery, is counterbalanced by a presentation of self as ready to take on her own recovery responsibilities with the impending hip replacement. Given the dramatic and moral character of the story it could be described as an 'atrocious story' (Dingwall 1977).

Participants 6, 8, 16, and 18 (B, A, A, and B) all had had (16 and 8) (A) or were having (6 and 18) (B) very difficult post-discharge recoveries at time of the home interview. Looking at Participants 8 and 6 (A and B), both gave what could be termed 'exit atrocious stories' which were illuminative through 'contrastive rhetoric' of the shifting of responsibility between self and others which appeared to be part of a larger



sense- making activity that all the participants did. After presenting an atrocity story of a previous brush with doctors, Participant 8 (A) returned to the most recent surgical experience:

*R...after you get over..the worst two or three days as a matter of fact, it's really surprising, how quickly you do come on, after the hip operation. You do come on quite quickly, **but I just felt, that, I was just put out before I was ready. I really wasn't walking properly** and they said they would get me a zimmer and I never got the **zimmer**, I got a zimmer phoned by the social services here and they brought a zimmer but a few days later, I had to go without it for quite a wee while before they finally sent it to me. **But ehh...I still think they put you out just a bit too quickly, mind you everybody wants to get out***

*FM Mmm*

*R...that's the truth.*

*FM Mhm*

*R.. I was desperate to get away too, but they should have..*

*FM When...Well, somebody must have talked to you about getting out then?*

*R No, they just said eh...yeh about the Tuesday, the following...you know that was the Tuesday after the operation, about a week after the operation, they said, 'Right, you can go on Friday, Mrs---', you see? And because you got to have time to get someone to come and take you home and all the rest of it and get your house ready for you. But no actually, they never said, 'Do you feel able?'. They never said that. (8.2 p7) (A)*

Through contrastive rhetoric some self responsibility was acknowledged but 'they should have' was the stronger assertion. In this atrocity story Participant 8 (A) seemed to be addressing an unstated question, that is, 'Why haven't you progressed?' and presents an answer. She was discharged too early. Although she was keen to go, but then 'everybody' does and by generalising she makes her own behaviour reasonable. However, the doctors have the ultimate responsibility to ensure her well-being. This theorising had been reinforced by the earlier atrocity story and provided further credence for the listener, of who is to blame for the poor recovery experience of Participant 8 (A). A 'topic-centered narrative' (Reissman 1993, p18) continues episodically with Participant 8 (A) putting forth her theme about the failings of the hospital staff (no dietary

assessment and a lengthy wait for admission purposely instigated in the hope that 'she might die off before we need her'). Then after such assertions of blame she apparently absolves the doctors :

*FM So, you were in...you went home on the Friday..so that would be, is that eleven days?*

*R Ai ten days actually*

*FM Ten days after your operation*

*R Yes, Tuesday, Wednesday, Thursday, Friday, yes, but eh, it was, I felt it..it wasn't really their fault I think I was pleased to get home, because I just felt I was coming home to die. I didn't think I was going to get over it anyway, when..at least once the flu got going 8.2 p8 (A)*

Representational ambivalence concerning professional and individual responsibility continued. It was of note that there was use of an event which post-dates Participant 8's (A) discharge, namely her getting flu, to produce a queer kind of exoneration of the health professionals. A 'narrator's license', was used to recontextualise her situation, to lend weight to whatever or wherever Participant 8's (A) sense-making activity was going at that particular point in the conversation with the interviewer. That narrative is not necessarily chronologically arranged but theme-based should also be also be noted (Michaels 1981 in Riessman p17). The theme under scrutiny being the reply to the perceived unstated question that was why she, Participant 8 (A), had not made a successful recovery.

The development of a post-discharge wound infection was posited by Participant 6 (B) as the root of her bad recovery experience and throughout the rest of the interview this theme was the focus of her responses to questions and the spontaneous talk she initiated. Dependence, age, unknown future, vulnerability were, in that order, talked of. Then began another 'exit narrative':

*FM () that's right, you'd never had an operation before*

*R Absolutely horrendous, I couldn't believe it*

*FM What what was the...*

*R You're not there at all, you are your chart, that is you. You may be lying in the bed but the person you are is your chart and em, your age, your name, all*

*this is on your chart, they hardly glance up at you, all the details you're not a really a person you're someone... they take you in and chop you up and do what they think to you and then they send you home, end of story. Eventually they will say, ' Well, you come back and see me in clinic in six weeks to two months time', and you feel very much on your own, you feel..... **I can't understand, there's no personal, there's no actual interest**, and this is the difference between private and the-----((names the hospital)), that is definite, big, big difference, there's*

*FM Because, you've, you've been in a private place as well?*

*R Not for operations but anything that's wrong, I've gone there. Not big operations but anything that was wrong and eh, you are a person. To understand this.. and in the hospital em.. and what I was saying was is.. It is a teaching hospital and considering you're getting it all for nothing then they are at liberty more or less to handle you any way they like. So I had a look at this...operation and in the beginning six inches and the stitches were so perfect, really dainty little stitches and I could tell you how many people must assume the stitches completely different the first two stitches and that no infection at all.. very neat and very closely knit so someone, whoever did that was an expert at it, the rest are all having a go.*

*FM You think so? (( laughs slightly )) (6.2 p4)(B)*

This narrative seemed to bear out Early's (1982) view that narrative is a form of commentary. There was a quality of distance in how Participant 6 (B) presented her situation. This can be seen in the excerpt above. The point at which she changed 'footing' (Goffman 19981) and returned to the interview in the first person, made clear how narrative can have a documentary style. Further on after further episodic narrative focusing upon time and being rushed through the pre-surgery time and the 'horrendous experience' of sharing the ward with several amputees:

*R I didn't hear anybody complain, the whole scenario, the whole treatment, but then maybe it's a fact of life but maybe I'm wrong, you know, I don't know, but also my GP. **She's been in and out, in and out, the nurse has been in. This all extra work to them, the infection part***

*FM Mmm*

*R ..and even, before I left, I did say, I was looking at the wound as I was going away, I was very keen to get home, I but the wound was still very raw and ehh,*

*it hadn't joined at all. I remember 'You think that's alright?', because it was about two inches awfully inflamed. It was within, I'd say twelve to twenty-four hours dreadful mess, it was really horrendous and then as I say, the poor doctor has been in, the GP has to come in. She has been very, very faithful and then the nurse has been in every day, to bandage it you know. **That you feel it's double nursing, it's double expense, whereas if it had been alright at the beginning, they could have saved themselves a hell of a lot of...** But then again everybody says to me, 'Oh,.. But why should one have to accept that? This is what I can't understand, why should there be infection when there is so sterile, everything is so meticulously done that I don't know where it came from, because the operating theatres are really, I imagine, very, very clean. (6.2 p5)(B)*

The tone of this talk was very distressed and perhaps as a result there was less preoccupation with the presentation of self responsibility. However, there was some morally motivated accounting activity, ( Silverman 1993; Baruch 1981) in the way that Participant 6 (B), in her justification for her negativity concerning her hospital care, theorised about how much the health service resources were burdened due to her infected wound.

Participant 18 (B), was still experiencing severe problems two months after her discharge home. Overall, not surprisingly perhaps, given the time gap, the conversation was much more developed around her recovery at home rather than her hospital stay. This was also a feature of the home interview with Participant 16 (A), five months after her discharge. However, unlike Participant 16 (A), Participant 18 (B) was still in the throes of a very uncomfortable, dependent and confined experience with recovery as she was still not 'recovered' enough to have been:

*'able to wear shoes and be able to get out and walk an...' (18.2 p5)(B)*

Her overall presentation was to do with how she had been handling the situation which she owned was down to her cigarette smoking:

*R..anyway but if I was able, I would go out. Even the girl next door, she had a Pip a Dee and she asked me in but, as I say I can't sit very long in the one position. Seat to seat sort of thing you know?)*

*FM It sort of isolates you*

*R It does, I feel very isolated but then **this was self inflicted**, cigarettes*

*((researcher gives a sort of strangled laugh because she is uncomfortable with how to respond))*

*FM Do you still?*

*R I've had the odd one, but I'm no smoking then very rarely, very rarely, very rarely....**which I cope with**. (18.2 p6) (B)*

Personal responsibility as it was presented here was to do with acknowledging 'fault'. Taking the perspective that accounts are motivated portrayals, why there seemed to be a need, on the part of Participant 18 (B), to do this, may have been related to who she thought was (the researcher) or would be (other professionals or the general public) the 'audience' (Silverman 1993). She may have accounted for her past smoking in this way so as to legitimate her position as someone doing her best to deal with her situation (Radley and Billig, 1996). Admitting 'fault' may have been part of Participant 18's (B) 'repertoire' of ways to present herself as being credibly responsible. That this may have been the case was possible given that in her recovery account there was a strong stoical theme - 'it had to be done and they did their best' (18.2 p7). There were fleeting references to a missed and mourned sociably active lifestyle which provided 'glimpses' (Dingwall 1997), of the devastating 'reality' of Participant 18's (B) 'recovery' experience.

In summary, both groups of participants displayed self-responsibility in recovering from surgery. This took various forms. There was: self-reporting cooperation with carers; following medical advice; working hard at recovery and not 'lying down to it'; overcoming mental discomfort with age-related prosthetics; stoicism and buying good shoes. Where there had been complications with the recovery, there was a good deal of sense-making activity by the affected participants in which responsibility was placed upon health professionals, albeit in a tentative way. Self-responsibility was also presented in the form of offering admissions of 'guilt' in relation to illness causation and delayed recovery. 'Self-infliction' talk was a feature of a number of the accounts from the Ward B participants only. Extrapolating from Crawford's (1993, p133) view that 'Talking about health is a way that people give expression to our culture's notions of well-being or quality of life', it would seem that studying how people talk about recovery

may be revealing. From this examination of the transcripts, talking about 'recovery' seemed to involve presenting oneself as a moral person who shares the values of a culture in which personal responsibility for one's own health looms large.

## Part 2: Rehabilitation in hospital

### *Section 1: Evocation and theory of the communal in Ward A.*

It is suggested that the participants' experience of recovery in Ward A was portrayed primarily as a shared experience. This was done in two ways. One way was through narrative which conveyed a sense of what it felt like to recover in the ward, that is recovery as narrative. The other was narrative which took the form of theorising as to what it was within the ward that was therapeutic and aided recovery, that is, narrative about recovering (Hydén 1997). In both forms what featured strongly was the day-by-day scheduling of professionally prescribed events for the surgical patient to experience. How this was done will be examined. In addition, what might have been the motivation for such narrative representations will be addressed.

The most direct referral to the existence of schedules or routines, was in some participants' theorising activity concerning what had assisted their own and fellow patients' recovery. This theorising as to the benefits of routine in assisting rehabilitation was aired the most clearly by participant 11(A):

*FM Mmm...So, well, I'll ask you one or two questions I've got down here, em....eh...I saw you at least once after you'd had your operation. Can you tell me about a time when you were .. an incident or period in hospital when you thought, 'This is me, I'm getting better'....'I feel better..' 'I feel I'm getting somewhere'*

*R Oh, yes, but before that. I had the operation on the **Thursday** and on the **Monday** I really thought I was finished. I had been on morphine sulphate for...I've lost count, six or seven weeks. And then I had a drip into my hand with something else to wean me off it, and that **Sunday** I really felt, I'd never so rotten in my life till that **Sunday**.... and there was a male nurse, in the ward, who really...he should have the George Cross it was wonderful how **he'd jolly we women.. out of**..you know*

*FM Mmm*



R it wasn't a case of, 'There, there, it will be alright' 'Come on you can do it' and he got me up on my feet, and got me on a zimmer and more of less said, **Right...walk!** and I found that I could walk... stagger but by the **Monday**... my depression had gone in so far as I knew my legs would move I was lying in bed on the **Friday** after the operation and on the **Saturday**, he got me in a wheelchair for lunch, but on the **Sunday** I don't think.. and say by the **Tuesday** or the **Wednesday** afternoon having had. I mean the first day I went down to physiotherapy on **Monday**, that..I wasn't very great, I couldn't do very much, you know, but by the **Wednesday** I was walking about, on parallel bars, hanging on for dear life but at least my legs, this leg was moving. By the **Friday**, well... so I would give every credit possible to that male nurse in the ward. All the other nurses as well of course but, he was contributory factor () depressed () done a great deal, then there were the physiotherapists, two of whom looked after me. I mean it wasn't the case of, 'Now, this will be sore', it was, 'You do that and get on with it' and you **felt well the other people were getting on with it too**, I can't () **So as a team**, I would say that I hope I never have to go back, but I wouldn't have any hesitation()after me

FM It sounds as if you felt they were very business-like

R I wouldn't...I wouldn't say business-like but I would say it was exceedingly well thought out

FM Yes

R It's obviously something that they're doing week in, week out

FM Aha

R and it is obvious I wouldn't say business-like because it wasn't impersonal in any way[ but,very

FM [Mmhm

R well thought out and ... if I could use the phrase, 'conveyor belt' system: you had the operation, then the next day something happened to you, the day after something happened to you. You had the operation at the end of the week, by the Monday you were down to the gym for physiotherapy, five days of that and then you got your stitches out and you were assessed and told you could go home

FM How do you feel about that?

R Oh, I thought it was great! Once I had the confidence

*FM Yes*

*R As I say the first few days....*

*FM Did you see other people and that sort of....maybe a few days ahead of you?*

*R Yes exactly and eh, you realized that eh .... to a very great extent it was up to you there was nobody going to hold your hand and I think that's the right approach. .... They were kindness itself if you needed help. But if you were to get up and walk about,- 'Of course you can, come on'. Everybody was kind. I hope it's never necessary but certainly I wouldn't hesitate, it's a wonderful place. (11.2 pp6-7) (A)*

This excerpt has a documentary pace, conveying an action-packed experience and was temporally contextualised by Participant 11(A) as a story with a particular beginning. She told her story from where she saw the beginning (seven weeks at home on morphine) and in so doing, gives the narrative a dramatic quality. This temporal contextualisation by Participant 11 (A) also acted as a method of constructing her biography around the surgical experience (Hydén 1997). As her narrative about her recovery moved along, it seemed clear that her ability and/or partiality in presenting her account through time was assisted by the existence of a day-by-day remobilization routine. In this way the experience of process was represented. The operation of a defined rehabilitative routine which was recognised by Participant 11(A) as one that she shared with the rest of the patients in the ward, was made clear. Her talk represented herself as an individual with a responsibility to 'try' which was encouraged by the care staff who were described alternately as sargeant majors and as paragons deserving of medals. In a story within a story Participant 11(A) singles out one nurse for special mention. This is the story of her first walk and it appears to have been aimed at describing what could be termed the 'rehabilitative style' of the hospital staff. Significantly, several of the other Ward A participants used this same vignette in a similar context.<sup>1</sup>

Most of Participant 11's (A)portrayal of the experience of, what could be termed, a communal recovery as it operated in Ward A had similarities with Early's (1982 p1491) definition of a 'therapeutic narrative' in the context of Egyptian women's talk concerning

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<sup>1</sup> (for example- 6.2. p6 lines37-46; 10.2.p5 lines15-36 in similar positive and theorising terms )

health decision-making for their children. 'Therapeutic narrative' was described as 'a commentary on illness progression, curative chains and surrounding events-both relevant and irrelevant'. Such a narrative, she argued, functioned as a ritualistic way to work out the rationale for actions taken and to 'endorse a state of affairs'. It could be argued that Participant 11's (A) narrative was a distinctive endorsement of the shared character of a Ward A recovery experience.

In Participant 7's (A) account, which was in response to a question about an experience that made her feel things were moving on, much of the narrative was about recovery and there was a good deal of exploration of the idea of what made for a supportive 'atmosphere'. Like Participant 11's (A) talk, Participant 7's (A) account seemed to represent and endorse a collectivised experience of recovery.

*FM Was there something about the hospital experience, that you felt; yes this is me.. getting over this or..*

*R Yes, hard to say really cos **there seemed to be a sort of routine, day one this happened and day two the next thing happened you know, you..you certainly noticed it when the next people came in and you said, 'Oh yes, that was what I was doing two or three days ago and the hips were doing something and the knees were doing something else you sort of obviously if you're doing okay, you follow into the routine***

*You know you just give*

*FM*

*[Yes*

*R yourself up to them and do as they say, don't you really? You know ..I must say I've got full marks for the staff there, they were marvellous. The sort of atmosphere in the place. They were always pulling my leg about things....*

*R Yes, yes, yes, however, you know you've got to get on with everything haven't you, do what they say, and eh, it was a very supportive all the other patients, you get quite a sort of rapport, especially with the ones you go in with, and you're so pleased when they manage to walk that bit better than they did the day before, that sort of thing. It's a very supportive atmosphere, I thought I'd definitely wouldn't want to be in a single room. I think that would be horrible.*

*FM mmm*

*R Yes, yes, and at times at night, it would be quite nice to be on your own but, but eh, generally speaking, you know, the, the and they answered the bell right*

away, you know the staff were great yes. **And the day I walked**, I was told to walk down and get my lunch in the day-room and eh, I hadn't put this..er what do you call it? ..splint thing on again and one of the staff came up and told me, in a nice way sort of told me off..very..but..I mean I hadn't realised how important it was to put it on, you see and 'don't for goodness sake walk without it again' you know but he didn't **tell me off in front of everyone**, [ he was just.. just made sure I realised ..yes and I em.. I just thought that was a really

FM [No

R nice sort of atmosphere very, you know, very caring atmosphere

FM Oh that's good

R Which of course, is how it ought to be, [yes, yes, but it was the way it should be, you know, yes

FM [Yes, yes

R so...eh..**I guess I sort of recovered according to plan**, you know ((laughs)) yes, yes anyway I got out after twelve days so they say ten to fourteen the normal so, so, I obviously...did as one expected to do so. So eh I don't think I felt I should be doing especially doing better or worse or anything you get sort of get swept up along with it all don't you....so... (7.2.pp9-10) (A)

The existence of a surgery-specific rehabilitative routine was clear to the patient. It would seem as if she was developing her ideas of what it was that was therapeutic about the ward as she spoke. The routine seemed to lie at the root of her ability to make comparisons as to her progress through the observation of other patients. Her comparing activity seemed to convey something of the visibility of the system operating within Ward A. Of particular note was her reference to the generational nature of the patient population enabling her to observe new patients going through the same experience within the routine that she had had a few days previously. Roth's (1964) T.B. patients were involved in a similar activity which enabled them to work out their own therapeutic 'timetables'. In a sense the routine was her recovery. This seemed borne out by her commenting that she had 'recovered according to plan'. Her representation of recovery was of a shared experience of a professionally prescribed routine of remobilisation. There was the casual, 'off the cuff' throw-away line of feeling progress as a predetermined and communal 'swept along' process. This presentation was interesting

because it seemed to provide ‘glimpses’ of how it felt to recover in the orthopaedic, Nightingale ward as well as being something of a commentary upon the ward’s social climate. The researcher suggests that Participant 7 (A), attempting to make sense of her experience developed her theory that a ‘supportive atmosphere’ existed in Ward A through talking about her relations of ‘rapport’ with, and visible access to, her fellow patients.

*FM Em, another question, how was your recovery talked about while you were in hospital and by whom?*

*R Mmm! I don't know that it was to that extent actually, you know, I can't specifically remember that it...*

*FM Maybe when you were talking before about[ the atmosphere and the patients and the staff*

*R Yes, and the other patients were who were just going out, were telling you, you know, what it was going to be like and everything yes, yes, they discussed. Don't know if it was specifically mentioned as a subject, you know, it was just one of those things that just sort of evolved really I think, (7.2 p10)(A)*

Accepting that this answer was to some extent interviewer prompted, does not, in the investigator’s view, diminish Participant 7’s (A) production of the concept of an evolutionary process at work which appeared to support, inform and educate Ward A’s patients. Indeed Mattingly (1994) would argue that narrative derived from conversation is characterized by ‘emplotment’ meaning that both narrator and listener seek to make sense of what is being addressed and develop it into a meaningful whole. Participant 7 (A) went on to develop her concept of ‘atmosphere’ describing the ward staff’s talking to her about her recovery as ‘in the background all the time’. She followed this with narrative about her past surgical experience, theorising as to an institutionalization process at work upon patients in benign terms as being part of a ‘close knit little circle’ (7.2 p11. lines24-31).

After being asked the same question as Participants 7 (A) and 11 (A), (i.e. about a particular experience which signified progress towards recovery), Participant 10 (A) talked about what appears to have been her first walk. This like all the other ‘first walks’ talked of by Ward A participants was unaccompanied. Accomplishing a slow and painful

journey to the toilet on her own was in her view worthwhile because, she volunteered, it was a confidence engendering experience. Echoing this view was Participant 5 (A), who in response to a similar question, described in positive terms the ‘letting go’ of patients by the staff, ‘You had the freedom you see to encourage yourself?’ (5.2 p9). Although Participant 9 (A), eight weeks out of hospital, had little to say about the hospital experience, always changing the focus of the conversation back to her present situation, she produced a short narrative which echoed the pace and progression of Participant 11’s (A) ( 9.2 p6 l.23). A routine focused upon progressive ambulation with each day another step forward seemed to be remembered.

In Participant 4’s (A) account of recovering, an identifiable routine which is common to all the patients having similar surgery enables comparisons to be made and as a result, as Participant 4 (A) presents it, decision-making as to what she will aim for in her own recovery. Within a context of a very visible, system of progression, a hard working, motivated portrayal is likely to be adopted as a morally appropriate way of representing one’s part in the system (see page 94 of this chapter for excerpt).

Other Ward A participants (eg. Participants 7, 8, 11, and 15) displayed specifically altruistic narrative which indirectly gave further nuances of a shared experience. An example of this was Participant 7’s (A) dramatic ‘before and after surgery’ story of another patient’s improvement in health and wellbeing. The telling of such a story as well as providing a ‘glimpse’ of the high visibility of ‘others’ progress also suggests that the visibility of such success may be of therapeutic value to the observers. In all the narratives from the Ward A participants a common theme emerges from the talk of routine, ‘others’, ‘first walks’, setting targets, making comparison with other patients, talking to other patients. This common theme is membership. Intentionally or unintentionally, what is evoked is a sense of participation in an activity.

Participant 16’s (A) account alternately was overtly and covertly critical of her hospital care. It is to be remembered that she was the only Ward A participant to develop a post-surgical complication, a wound infection. The presence of community was evoked in her narrative of her first walk to the shower story as a means to justify her negative response to the question of what was helpful in recovering in hospital and for managing at home:



*R I don't think any...as a matter of fact, I was a bit surprised, because my () the first when I was told I could have a shower or a bath **nobody** said to me, 'I'll chum you through' and not a auxillary, not a nurse, I just went through to the bathroom on my own. Now...eh..I forget the German lady's name, somebody went through with her whether it was because she had a hip maybe she needed a bit of help to get into the bath, I have no idea but I would have thought at that particular point, that it would have been better had somebody at least offered, and taken you there and said, 'Will I leave you now,' eh or 'I'll be back in five minutes' and I think that's..I think that would have been much more eh..acceptable instead of just sort of saying, 'Well you can have a bath now' and that was it.*

*FM Mmhm, mmhm*

*R Mind you I like my privacy, ah ah, maybe they thought you know, I'll just leave her to get on with it. **But I do think for the first time that somebody should have accompanied me as a patient...to the bathroom and said, 'Will I stay with you? Will I help you' and I could have said, 'No thanks I can manage fine' but that's my that's the only criticism I have there.** (16.2 pp8-9) (A).*

Dissatisfaction with her care was encapsulated by Participant 16 (A) in making a comparison with how another patient's first walk had been 'accompanied' and hers had not. It could be mooted that some sort of communal experience underpinned reality for Ward A patients. Why this may have been the case was because knowledge of the fate of others and comparison of personal care with that of others was present in their talk no matter the individual context of the participant.

This sense of community or 'atmosphere' to quote some of the participants, was presented as a benign entity, a good thing across all Ward A accounts. The investigator associated these presentations with the descriptions of, and allusions to, what seemed to be a very visible rehabilitative routine. The assumptions of a shared reality made by the interviewee of the investigator seemed to contribute to the successful promulgation of a communal proposition of reality (Bourdieu 1990). In addition, the investigator, although she had never been a patient or a member of staff in Ward A, had had much experience of carrying out rehabilitative work with surgical patients. As a consequence, propositions

from the participants of the everyday reality of Ward A as a communal experience, may have been more easily recognised as such.

Within Participant 16's (A) talk there was an episodic narrative, the subject of which was the poor care she experienced in hospital. Initial listenings did not at first produce an ongoing story being told as there seemed to be so much subject switching. However, it became clear that the topic switching was to do with finding as many ways to account for her negativity towards the ward and the staff. From the above narrative Participant 16 (A) considers that she should be accompanied but at the same time she presents her independence and grit in liking her privacy inferring in this way that she would not have taken up an offer to be attended. This topic had been raised before by Participant 16 (A) and the extract below seems to be an elaboration upon her theory as to what the role of a qualified nurse is:

*FM So...em..when you were in hospital how..how was your recovery talked about or em... who talked about it? What was there about said particularly about you getting through this and coming home and.....?*

*R No nothing very much was said about that at all. As a matter of fact it was the auxillaries that did most of the...the work. **I didn't see very many nurses doing nursing as such I think nurses now have a different turn to their profession.** Nurses, **a** nurse came and eh..handed out eh, tablets but it was the auxillaries who did the beds, and eh..you know... the food. All that was done by auxillaries and occasionally you'd see a nurse coming with a folder under her arm or something but walking right past you. And again, I was terribly impressed with that I prefer the old fashioned way of nursing nurses, nursing ah..auxillaries doing subsidiary work **but essentially with patients, nurses should be there to attend. I mean a nurse would take a blood pressure or a temperature certainly, but that was about it.** (16.2 p8) (A)*

To illustrate the apparent topic switching what happened next was that she then launched into an analysis of what she thought was the focus of progression to recovery and again it is one that is bereft of attending, and interactive health professionals:

*R Aah...and as far as getting on you..you ...by the way that your leg was, **well by the way that my leg was bandaged first of all a plaster and then the strip down there and that seemed to be the progression, the dressings seemed to be the***

*progression, eh.. rather than any doctor or nurse coming and saying, 'Well this is a big improvement, yes we'll put on a strip today because I didn't feel it was like that....em.....doctors I can't remember.. (16.2 p8)(A)*

This patient analysis was strikingly similar to that of Participant 6's (B) another patient who had had an uncomfortable recovery and who was very unhappy with the care received. It may be argued too that it corroborates Fox's (1992 p86) argument concerning surgeons' discourse on wound condition as a 'distancing' manoeuvre by surgeons, one which prevents much in the way of patient input. It may be that it is through the talk of those who are unhappy with their experience that one is most likely to glean the most detailed portrayals of that experience, because there is a need to justify possibly at length, their dissatisfaction. In relation to this, Participant 8's (A) account was of interest as she too seemed to have had a surgical outcome, which had not gone, to quote Participant 7 (A), 'according to plan'. From the details given to the investigator by a staff nurse, when she called the ward to inquire, Participant 8 (A) had not had a successful result and as a consequence of this, she was destined, it was thought, for a nursing home instead of the little flat she had described pre-operatively. Participant 8's (A) account of her experience post-surgery up to the time of the second interview a month after her hospital discharge appeared to have little concurrence with the professional view. Her account of her experiences is studded with atrocity stories of her past experiences focused particularly upon doctors' ward rounds.

Her commentary culminates in a theorising as to why she has made little progress. Her theory as to why she had not yet achieved her recovery goal of walking and 'going to the shops', was that she had been discharged too soon. Her atrocity stories have been made to provide an element of personal action. It could be argued that if these stories were not there, Participant 8's (A) account, would be one of failure and passivity. It was clear to the researcher, and confirmed by Participant 8 (A), that she was no more ambulant than she was before she was admitted and in fact, was able to do less than previously. Her commentary on the ward round stories therefore seemed a way of injecting her participation into the account. In this way moral worth was associated with the participant, no matter how 'unworthy' the narrative content has been. This view is further established by the lengthy narrative Participant 8 (A) produces at the beginning of

the interview in which she seems to be setting the scene and the rationale for her 'failure' to progress (pp5-6). Her age, hospital acquired flu, lengthy wait for admission, and pre admission anorexia and resultant malnourishment are all touched on after the investigator reminds her of the research objective to investigate the process and result of surgery for the participants. Two ward round stories follow this and then she continues in her earlier documentary and theorising style to provide further reasons for her lack of progressive recovery (see p 101 for excerpts).

Apart from justifying and making reasonable her lack of progress, Participant 8 (A) appeared motivated towards telling her story with a particular audience in mind - that of the health professionals. She actually alluded to her intention shortly after this when the investigator was reassuring her as to the confidentiality of her interview:

*R No I hope, I hope that they would pay attention to that really because I don't think enough a*

*FM Mhm*

*R.. attention is paid to that ..eh, pushing you out too quickly. I think it's the one....the only I think the National Health Service is absolutely wonderful but that's the one thing, they are apt to push you out a bit..especially if you're old, and you are really not ready, prepared for it ( 8.2 p8)(A)*

There are always going to be patients whose recovery does not go 'according to plan' (participant 7 (A) p10 line22) and how they fare within a system geared to specific rehabilitative goals may be a moot question. The Ward B accounts provide further insights in relation this question. The evocation of 'community' seemed to contextualise individual efforts to perform well, to make clear how well the individual has done through comparison with others and so be cast in a good moral light. It was also integral to accounts which were about justifying dissatisfaction with care, by making comparisons with the care given to other patients. The other motivation for giving a communal slant to recovery accounts, it could be argued, is down to a loyalty to the memory of an experience shared and to the ward staff involved in some way in that sharing.

## **Section 2: Ward B**

The Ward B accounts of recovery from surgery will be examined from two perspectives: comparatively with Ward A participants and as stand alone accounts of

recovery. As has been argued in the previous section, accounts of recovery from Ward A participants are distinguished by the sense of shared travail. No such evocation of community could be elicited by the investigator from the Ward B transcriptions. The existence of others was rarely alluded to and when they were, the motivation for doing so was less easy to make sense of. Participant 6 (B), referred to her fellow patients to portray them as naïve and perhaps duped by the professionals into thinking that their consultants were personally carrying out their surgery. Before this excerpt she had just been theorising as to the possibility that more than one person had ‘had a go’ at stitching her wound:

*R Then you say, I was under Mr---- 's((names consultant )) team and the laugh is I was talking to one or two patients there and they were all telling me that Mr --- --had done their operations but he must have( ) that was utterly( ) but we never are ever told*

*FM You never knew who'd actually done the operation?*

*R No, no, I did ask and I was told ' Oh, I don't know I'll look up your notes ' ((uses mimicry )) and I asked again, 'Oh, Mr --- ' but never confirmed( ) this is understandable, I don't expect them to, I know, though I did ask at the very beginning who was going to do it (6.2 p4)(B)*

A little later she was still accounting for her dissatisfaction with Ward B. She had been talking about her speedy pre-operative preparation:

*R Everything You didn't have time to think and then you were taken back to the ward and they were so quick. You're not told **what phase it is**, you're just told, 'You're going for an x-ray now, you're going for cardiograph, you're going for something You're back in bed and in the morning, you're whisked off I don't know, ( ) allowing myself to go... **Maybe that is the procedure, maybe that is the way it goes**, I don't know, it was just an awful shock the way I came round.*

***Then you're put**, of course from the psychological point of view, it was horrendous. I knew the lady two beds down from me and I was shocked when, she stays() and I was shocked when she told me she'd had her leg off in here and then the lady she had both legs. Across the way a young girl was getting ready for her amputation. **The whole place was so.....the effect was dreadful for me.** I know they don't have the money nor the accommodation to ahh, separate, which is very bad like you're putting them among all these people with amputations. I*

*think it's very bad, like you're putting them among all these people with amputations, that was something...horrendous, you know (6.2 p5)(B)*

Unlike the Ward A participants theorising as to the therapeutic effects of a perceived shared experience, Participant 6 (B) described the harm to her in sharing the ward with people who had had amputations. Representing this harm from a 'psychological point of view' gained a moral and 'scientific' credibility to her account. Of further interest in this excerpt were the 'glimpses' of a less articulated need for knowledge to do with the timing and routine workings of Ward B. Further reference to the communal was identified in the following ward round story from Participant 6 (B):

*R Horrendous, however....It maybe the greatest, I don't know. I couldn't sleep I'm moaning yet so many people there () actually I was told that, during one of the VIP visits, I was told that*  
*FM VIP visits?*  
*R Oh you know, the consultants the doctors*  
*FM Oh right*  
*R .. and I was told I ought to realise I was the only one they really weren't concerned about. That says something Anyway, I'm all negative I'm not positive so therefore it's eh, worse.. If you're very, very positive, I think you make progress.....much quicker. But not this up and go () I look on the black side*  
*() ((says something amusing as we both chuckle a little)) (6.2 p6)(B)*

This was a vignette told, it is suggested, as a continuation of her narrative upon the subject of the hospital professionals' responses to the condition of her post-operative leg. The narrative was of interest at several levels of meaning. It was a continuation of Participant 6's (B) story of dissatisfaction with her care. At the same time it 'glimpses' at a shared experience of being a patient in Ward B through what Participant 6 (B) recounts of the ward round talk. She portrays the professionals as linking her situation with the experience of the rest of the patients in the ward. This was interesting because such an evocation of the communal took place. From the account, an assumption was made by the doctors of the pertinence of the 'others' to Participant 6 (B). Of further interest was Participant 6's allusion to two formulas for recovery. One to do with the wider cultural (attitude) and the other a ward situated 'moving' of patients towards discharge. By the



latter is meant the health professional activity which redefines a patient's position in relation to her/his need for acute medical care. A similar activity was described by Latimer (1997).

When an amputee Participant 12 (B) talked of her hospital recovery, her representation of the communal experience was of the burden of having her recent amputation come under the gaze of her fellow patients.

*R So this is what, I think, everything I've settled in to thingwey, it's no, it's determination I think, I had to do something, that otherwise I would, I don't know where I would be the day if I didn't try and I could, I could, I can reverse easily enough off a bed and even in hospital and that, off a chair and thingwey. So I mean, I managed up, I mean I was left mostly on my own because I seemed to have..em...done it for myself which helped the nurse and that. But ah...*

*FM Mmhm*

*R Myself you know, as I say, even transferring, you know, out of the bed, the only thing I felt in hospital this time was because of that, em, **it was awkward because a lot of the patients, well I was the only one last time, but a' different patients em, see you put that off and on, I thought, so em, I felt a bit more embarrassed then, than I... do at any other time, you know, just because some of the patients,[ they just like to know what's wrong and what..I didn't want to..although I'm talking to***

*FM [Mmm*

*R you about that...explain it all to them (12.2p9)(B)*

For this participant, recovery was represented as solitary distress. The researcher contends that this was a distinctive representational feature of Ward B interview narrative. The Ward B accounts were notable for the relative absence of direct or indirect referral to the other patients. When the participants did place themselves within a context that was shared with others, it was as an individual having a difficult time. There was no sense that this difficult time was shared in any positive way with others. More specifically, there was no representation of a membership of any sort of patient group. In the first interviews, apart from those of the two participants who were awaiting minor surgery (Participants 1 and 2 (B)), a high level of distress was overtly and/or covertly displayed. For example, Participant 14 justifies her delay in agreeing to surgery by saying

‘It’s not a tooth I’m getting out’. There was overt distress from Participant 13 (B) in her pre-operative interview. She talked at length (requested tape off at this point) about her husband’s recent serious illness. The knowledge of this combined with the news that she needed surgery for her gangrenous toe had prompted her husband and herself to review their life circumstances, in particular the need for them to move from the top-floor flat they had lived in all their married life. Participant 3 (B) was facing surgery which could save her from death or disability through arterial disease but at the same time the surgical intervention itself could result in a cerebral vascular accident. Initially she owned to being very fearful (3.1 p1 lines 5-13) but then the account became more covertly distressed. When asked what she thought was involved in getting over the surgery:

*‘R I don’t have the fear that I won’t get over it. I mean I’ve seen this operation on the television It’s a fragile operation, because I’m a lot, well I’m not a lot younger, but a bit younger to the age normally have this operation, the chance is I’ll get out a bit quicker, that’s what I ‘ve been told’*

She displayed what could be described as bargaining talk - ‘youth on her side’ - and the authoritative voice of the surgeons was used to give weight to her case for not being fearful. The bargaining thread was woven into Participant 3’s (B) narrative:

*R After I heard how long it takes **anybody** to get over this so I keep thinking I’m going to be as right as rain when I go out... (3.1. p3)(B)*

and referring to a TV documentary she had seen which had dealt with her condition:

*R This had said that it is now quite a **common operation and that it is a fragile one, but it is quite common** where they cut the artery, clean it, and put it back, put you back again together (3.1 p3)(B)*

It was of note that the experience of an ‘invisible’ peer group, from the world outside Ward B, was introduced as a further prong to Participant 3’s(B) case for justifying her presentation of the surgery she was to undergo as ‘common’. ‘Common’ by her implication meant safe or survivable. This evocation of ‘others’ could be compared with those from the Ward A participants. Interpreting all such evocations as

attempts at contextualisation by the subjects leads the researcher to the conclusion that a claim to membership of a group or 'community' (Lave and Wenger 1991) is part of a 'repertoire' of narratives (Gilbert and Mulkay 1983 in Silverman 1993) of making sense of one's situation to oneself and to others.

### **Part 3: Rules of recovery and 'do as much as you can'**

It has been posited in the previous chapter that a distinct difference between wards A and B was the presence or absence respectively of representations of communal recovery in hospital. The representations of recovery experienced in Ward A built up into a quite distinct picture of a visible and shared routine. In this part some of these representations of routine will be examined again because of what they may have revealed about recovery learning. From both sets of accounts other insights were found with regards to the forms of guidance experienced by the participants.

#### ***Section 1: Do's and don'ts: Ward A***

It could perhaps be argued that Ward A participants were accounting for their experience of recovery within a framework which reflected professionally organised prescriptions of how patients should behave in hospital and when they go home. In portraying convalescence at home the talk of all the participants from Ward A was bounded by prescribed functional goals achieved or to aim for. There was much to say about how everyday life was managed according to the rules of movement given by health professionals. This choice of talk may have been motivated by the need to present oneself as a 'good patient' and Ward A patients, being as it were, 'rule equipped' had a repertoire of 'dos and don'ts' at their disposal. It is also possible that having been given a way of framing their experience, and being asked questions which were not of an everyday nature (Dingwall 1997), the professional prescriptions served as a means to represent their situation. Participant 15's (A) home interview is an example of a 'rule-equipped narrative'.

*FM Well, just to start us off I ask you, how did it go once you'd had the operation?*

*R Really I was surprised it has gone on very well and faster than I thought because () and they got me up in forty-eight hours. I got up with the zimmer*

*first, they gave me my first walk, () and then when I came home I managed to sit in the car, but, you know, the way they teach you how to do it (15.2 p3)(A)*

Something of the ‘conveyor belt’ experience (as termed by fellow patient 11(A)), the pace and concentration upon the restoration of function that was the Ward A rehabilitation regimen is evoked here. At the very beginning of her narrative Participant 15 (A) introduces the educational influence of the professionals in the context of making clear that she was adhering to instruction. A good deal of what followed continued with a compliant and rule-equipped presentation. For example:

*R.....So we seem to manage*

*FM Yes managing, what's managing?*

*R As they said I've not to bend down so, so when I go for my shower, my husband has to lift my bad as I call it, where the operation was you know in the hip so that it has to be lifted out, not me to lift it in cos the shower is in the bath and then eh..he has to dry my feet because I can't ((laughs)) (15.2 p3)*

*R No, I'm not allowed you see, in buses for eight months, the shaking and the..mmhm*

*FM Getting on to one!*

*((both laugh))*

*R I know and I'm not allowed to Hoover. I can do ironing sitting down, so that's no problem.*

*FM Why can't you Hoover?*

*R Because they say the movements, the gyrating .....so (15.2 p4)(A)*

Life at home was about ‘managing’ and that was seeking to adhere to specific rules of movement. Within this rule-laden representation there was, measurement of progress against an official yardstick with Participant 15 (A) presenting her success at getting home earlier than indicated in the ward information brochure (15.2 p4). However, at home there were some problems :

*R ((interrupts)) Well, I thought somebody would come and see whether I was doing the right thing or ((a little laugh))...My doctor came when I came home, em, after two days was it? em, and she () did but afterwards I didn't need to call her for anything, so I didn't, so.. The only thing the other day I phoned to see when you actually turn on the side of the operation and she said, 'You can turn now'*

*FM So who did you phone?*

*R My doctor because I didn't know I supposed to wait till the ----October or ()? and then I wanted to know, can I walk with one stick or do I still keep the two? She says, 'No keep to the two' You see I thought*

*FM Aha you have a teaching session don't you?*

*R Yes, we had that **but they didn't say to me when you stop using the two***

*FM Mhm, so I suppose when you came home you had a few questions*

*R No, that was all recently actually that I phoned the doctor to ask about this and about turning on the side of the operation was done. She said, 'Yes you can'. Because you know, **I'm still frightened to turn in case I do something wrong**, because why do you have to have that pillow between your legs. It's so annoying and so hot, you know, it makes the bed really hot, and I thought, how do you turn, if you've still got to have the pillow in[ you know like, but I tried, as I say I*

*FM [Mhm*

*R wasn't comfortable (15.2 pp5-6)(A)*

Participant 15's (A) portrayal of adhering to instructions given in hospital could have been a representation of 'the good patient' and she displayed annoyance at the lack of supervision she experienced to ensure she 'was doing the right thing' when back home. What is also of note was that she reported a lack of health professional guidance concerning the length of particular recovery phases. Baker (1989) suggested that health professionals do not provide sufficient 'phase progression cues' or 'yardsticks' to enable patients to recognise when it is appropriate to change activity levels.

There was another aspect to her talk which initially struck the interviewer as making the interview unsatisfying. Her responses were very bound to the rules of movement she had learned. Her motivation to use the rules of recovery as a framework to her

conversation may have been because they were what she was most confident to use and what she may have thought the interviewer would be expecting.

Participant 10(A) who had post-discharge weekly hospital visits for physiotherapy, gave a narrative with a theme which closely followed the line she took before her surgery. She wished to do more, and she had a son who thought her crutches were ‘magic things’ which would enable her to play with him. However, she had ‘resigned’ (10,p6) herself to a long rehabilitation.

*R Well, you feel, sometimes feels, you know, that I could walk without the crutches, but then if you walked without the crutches it would just knacker, [it would just take away what has been done*

*FM*

*[Mmm*

*R and you end up back at square one, probably back in hospital so..I may as well take the chance You know, I'm going to do what the doctors tell me me to do and what the physios tell me to do at the hospital.. I'm no going to try and dae it mair quicker [ because I'd probably dae something*

*FM*

*[Mmhm*

*R ending me back to where I started [and that's someplace no what I'm wanting. I want to get*

*FM*

*[Mmhm*

*.....mmhm*

*R to how I wis...well no how I wis before it started, em..get back on with my life (10.2 p7) (A)*

Responsibility was a recurring theme in Participant 10's (A) narrative and in the excerpt above it was about sticking to the rules laid down and in the knowledge of what her immediate future will be. She portrayed herself as ‘realistic’ in the first interview and this was continued with the rules of recovery used to emphasise this representation. It should be noted that the second interview took place in Participant 10's (A) mother's presence and in her house and this may have influenced the degree of responsible compliance within her talk.

Participant 9's (A) assertive account of her interview with the home care supervisor displayed a confidence of knowing what her activity restrictions were, using the rules to



argue her case for help. It was told as an atrocity story which functioned, it is suggested, as a vehicle for Participant 9 (A) to display her ability to manage at home with the support of her large extended family who were portrayed as going out of their way to support her in her own home.

Further rules of recovery may have become apparent through the experience of such recovery 'milestones' as the 'first walk'. All the Ward A participants (with the exception of Participant 8), talked of 'firsts'. These were first mobility experiences that were unaccompanied such as their first walk to the toilet or the first shower. It is the researcher's view that the vignettes about 'firsts' conveyed what could be termed the 'supportive abandonment' of the patients by the care staff. By this is meant for example, that patients were told they could go and take a shower and were left alone with what seems to have been an understanding that the staff would always be available if there were difficulties. That the staff may do some discreet monitoring of the patient's progress seems to be illustrated in Participant 7's (A) story. This was a 'the day I walked' story. Participant 7 (A) had been asked to get herself along to the dining area in the ward. On her way she is stopped by a staff nurse who gently castigates her for forgetting to wear her knee support. That further rules of recovering may have been made more accessible through first experiences is suggested in that these experiences tended to take place 'in front of everyone' (Participant 7 (A)). Not only does Participant 7 (A) learn to wear her splint for walking, other patients having similar surgery have been reminded or have been provided with cues for future remobilisation. In addition, the early and 'responsible' mobility that was expected of the patients, was made visible.

### ***Section 2: 'Do as much as you can', Ward B.***

Unlike the Ward A accounts, Ward B participants' talk of recovery in hospital and at home, was notable for the absence of representations or stories of compliance with a set of recovery rules. What was discerned within these accounts were a few 'glimpses' of what may have amounted to a much less visible, structured or predictable framework of recovery. Participant 1's (B) atrocity story concerning her unsuccessful search for what she termed the 'do's and don'ts' for recovery may provide some sense of the low visibility of rules for recovery in Ward B. Her representations of self-responsibility have already been related to her attempts to gain information from the care staff. Unlike the Ward A accounts, there were no experiences of other patients in the ward in Participant

1's (B) narrative. This may have been because there was only one other patient in the ward having similar surgery. It may be that her reference to acquaintances who have some knowledge about the surgery was an attempt at engendering a portrayal of shared practice. In the following excerpt Participant 1(B) linked the experiences and advice received from her acquaintances of **how** to recover with her own practice of **doing** recovery:

*R.....It's not the same sensation, and if I wiggle my foot about a bit, which I was told, not by anybody in hospital, but I've got a friend whose a district nurse.....and I was asking her as well and she said that, 'Why don't you sit and just move your leg backwards and forwards...(1.2. p10)(B)*

*R...I mean I have a friend whose is not the dramatic type ....she said she'd never experienced anything like it and that she certainly didn't intend getting the other leg done....so she never went into details I didn't ask her....(another acquaintance) again she didn't go into many details, ...She'd had this experience before, the surgery, which had really meant the surgery was more essential and also more difficult....(1.2. p11) (B)*

That there was a lack of clear cut 'do's and don'ts' for recovering seems to have been hinted at by the Ward B charge nurse's contention that it was not possible to satisfy the patients' desire for 'black and white' answers. That this stance may have reflected Ward B's general approach to rules and activities of recovering, seems to be corroborated by Participant 3's (B) brief assessment.

*R We didn't get anything like that, well I wasn't told anything like that. I just was told when I was going to the operating theatre, just to put the gown on that on an' that was it*

*FM And you asked about when you could wash your hair?*

*R She said, ' Just you carry on. Yes just wash it, see what you can do '. I actually think they want you to come back to normality as quick as possible and do try to do your everyday thing*

*FM Why do you think that?*

*R Oh, I just get the impression that they want you, up and about and, they don't want you to be lying in bed when you can up and about, they don't want to have to wash you if you can wash yourself. There's n.....*

*FM You got that impression from?.....what the?*

*R Em, well I think when I said to em.....((says to herself)) oh what happened? I was waiting for a visitor this afternoon and I says to , ' Could I go out and meet them?' She says, ' Certainly, mmhm,jus if you feel you can go for a walk, go for a walk'. There was none of this, 'Don't do this*

*FM Mmm*

*R If I asked, yes, by all means, do it and I honestly think that's how they really treat all their patients. To be up and about as quick as possible an', if you've got a problem, say to them, you've got a problem, you know. Does that help you? (3.2 p5)(B)*

In other words, some of the time at least, initiating progression in levels of activity was done by patients being enjoined by staff to 'use your common sense'. Part of Participant 6's (B) dissatisfaction with her care was briefly expressed in her talk about her pre-operative care.

*R Everything ( ) You didn't have time to think and then you were taken back to the ward and they were so quick. **You're not told what phase it is, you're just told,** 'You're going for an x-ray now, you're going for cardiograph, you're going for something( ) You're back in bed and in the morning, you're whisked off I don't know, () allowing myself to go...() **Maybe that is the procedure, maybe that is the way it goes..(6.2 p5 )(B)***

Not knowing what stage she was at or moving on to was portrayed as a frightening, and confusing experience. It is interesting that Participant 6 (B) should try and make sense of this experience as being a ward routine, as something that other patients might experience. Alternatively, she may have been making no generalisations to others' experience, rather that she may have been making an allusion to a standard expectation of there being rules in place to organise her experience.

Seeking, achieving or maintaining a balance between activity and rest in hospital and at home were themes common to several of the Ward B accounts. Participant 2 (B) portrayed herself as well organised and assertive with her family in ensuring that she had sufficient rest. In contrast Participant 1(B) presented herself as uncertain as to whether she should be pushing herself ‘through the pain’ as well as being worried that such behaviour would harm the surgical work. She had been talking about her efforts to recuperate responsibly on her son’s birthday:

*R ...of course the sitting with my leg down, for two hours when I stood up I couldn't straighten it at all, I had to literally hop to the counter so much so that the guy said, 'Are you all right?' ((laughs)) 'I've got a sore leg and it will be all right' and it was, it gradually sorted itself out but by the time I came home I felt totally worn out. I really felt quite shaky with it all and I had to really lie in a hot bath for ages before I felt all right and then the next day I couldn't, I couldn't really walk on it at all and that's why I went to the doctor yesterday. **I hadn't really wanted to waste the doctor's time, I didn't think there was anything wrong but this bit is very hot and seemed quite hard** and I just wondered whether there might be an infection and **because I really didn't know whether this was a natural process or not is concerned she said, 'No, no, that's quite natural and it em, and it will just gradually go, there's very bad bruising there and that's what is making it difficult to walk.'***

*So that in answer to your question was until today I would have said it is actually more difficult to get about, more painful than it had been the week before when it was just a matter of the wounds and the circulation sorting itself out. What I had a few days after I came out of hospital **which again I didn't expect was this sensation in my foot, in my ankle, it was almost as if I had sprained it and it was very difficult to get up the stairs, which again I thought, is this right, it has nothing to do with where they had been dealing with where they had been dealing with the veins***

*FM Mmm*

*R I think it must have been a circulation thing and it just sometimes a rash of pins and needles effect coming up there and sometimes it was like something clicking in and out of place, which made it difficult to walk*

*FM Mmm*

*R So I have kind of gone through various stages of discomfort in various parts of the leg and maybe it's different for everybody, I don't know, but if there was any comment I would make it would be, it would be nice to be sort of told or maybe it is the person I am, I like the i's dotted and the t's crossed but I feel they might have said, ' now this is likely to happen, and then this is likely to happen, don't worry if it does and don't go wasting our time if it does, because it is all quite normal*

*FM Hm Hm*

*R Because you really just don't know what to expect, what kind of pain you'll have or what sort of....Whether it's all right if your leg swells up or whether it isn't or you know anything like that*

*FM HmHm (1.2 p 4)(B)*

The narrative content of Participant 1's (B) account echoes the already mentioned work of Baker (1989) who found that the post-surgical patients she surveyed wanted to know more about the 'phase progression' of their recovery. According to Baker, health professionals' instructions lack the clarity needed to help patients in 'interpreting physiological cues' so as to recognise their physical limits. Several examples of physiological cues were talked about by Participant 1(B): her wound was 'hot' and 'quite hard'; she had experienced painful mobility and 'pins and needles'. She was a teacher and her narrative reflects an articulate understanding that she was in need of an applied form of knowledge of recovery (Carr 1981).

According to the Ward B participants, the only remembered applied recovery advice from health professionals was 'keep your feet up' (participants 1, 2, 6, 14 and 18) (B), 'use your common sense' (participants 1, 3, 18) (B) and 'do as much as you can' (participants 1, 3). These pieces of advice are of particular interest given Radley and Billig's (1996, p224) view that 'the activity of accounting is performed by those struggling to claim themselves simultaneously to be both active and inactive'. The contradictory enjoinders from the professionals seem to reflect a similar difficulty by them to portray the 'how' of recovery.

In contrast to the vagueness of the professional advice to do with the 'how to' knowledge (Carr 1981), that could equip a patient for example, for the interpretation of what would be safe levels of activity, there were stories from Ward B which suggested

that there was another form of knowledge-giving that might be favoured by the care staff. In the narrative from Participant 3 (B) there was glimpsed perhaps a partiality by the nurse to portray progress in recovery in scientific terms. The clearest example of this was found in Participant 3's (B) vignette recounting her and her husband's attempt to find out how she was doing.

*R -----(husband) had said, 'Has it been a success?'. She says, 'Well, all I can tell you just now is that **immediately it's done there was .2% more blood to the brain than what there was before like**'. Well to me that doesn't sound a lot, but then I don't know how much of a flow that is*

*FM Mmhm*

*R ...and then I just said to her, 'Well, can I wash?'. 'Oh' she said, 'just carry on and do what you can do normally' she says 'and you can always put some cream on that if you..' (referring to her wound)). But that was really...**nobody had said to me not to do anything***

*FM Hmhm*

*R..you know.....and I went to my own doctor because they gave me a letter () my own doctor and he said, 'Well, you been on suspense' he said () something 'Have you felt you've been on a time bomb, since you had it done?' and I said, 'Well, I just don't know what I'm able to do' and again he said, 'Do what you can do. If you can only turn to the left then turn to the left'. He says, 'it will all come back' and right enough it is all coming back. (3.2 p7)(B)*

The great conceptual distance for the patient between the knowledge about the physiology of her condition and the knowledge of the procedural 'how to' recover safely was glimpsed here. Equally, there was a contrast between the specificity of the 'scientific' information and the relative vagueness of the advice to do with the application of such information to the practice of recovering, given by the staff nurse. Participant 3's (B) narrative continued with the 'do as much as you can' advice being echoed a little more specifically by her G.P. That some sort of procedural knowledge was wanted by Participant 3 (B) seemed evident from her comment that no one had told her what not to do.

In Participant 1's (B) lengthy episodic narrative of her search for the 'do's and don'ts' of rest and activity for her post-surgical recovery, she made clear that she had



gleaned from various sources some understanding of her condition and that it is this understanding which justifies this search. One story she tells of an encounter with one of the ward nurses provided another perspective upon the charge nurse's view that there were no definite rules that could be given to Ward B's patients. The researcher had asked Participant 1(B) whether anyone had talked to her about her recovery:

*R Nobody really, to be honest with you. Em, when I went in to start with the nurse who signed me in or whatever the term is, sort of went through the procedure with me and said, this happens, someone will admit you, Dr..., I think his name is, will be round and at some point today, the surgeon or doctor will come and mark out your leg and em, will check over your blood pressure and all the routine things and then tomorrow morning, quite early, you'll have the operation and hopefully, all being well you'll get out on Friday and I said, 'What are, I know it's early days but what are the do's and don'ts about afterwards?' and she said, she sort of, you know she kind of went like that ((demonstrates a shrug)) 'Well it depends on the doctor you get' and I said, 'Oh another grey area in medicine is it?' and she said 'Yes, well it used to be the case, that they would say you have to walk miles, but we don't say that, we don't tend to say that any longer and it just depends on the doctor so I think I'll just leave it up to him up to him but some say you should sit with your foot up for six weeks, some say you should sit with your foot up for two weeks, some say you should walk, a lot, some say do whatever is comfortable it really does just depend on the doctor ((laughs)) (1.2 p5)(B)*

This narrative appears to provide a hint of a difference of opinion and possibly a lack of commitment to coordinate an agreed body of knowledge, amongst the medical staff. That this may be important could be interpreted from the nurse's response. What this excerpt may also suggest is that unlike Ward A, patients with the same or similar surgeries may not share recognisable routines of progression not only because of the nature of their illness, but due to differences amongst surgeons as to the appropriate way to recover.

In summary, the accounts from the two wards were markedly different, concerning the degree of apparent accessibility to knowledge concerning how to recover. This difference was related to several themes and characteristics of the two sets of accounts. Generally, the Ward A accounts were articulate concerning the course of recovery both in

hospital and at home. There was a good deal of temporal detail as to what happened and when. Much of this detail evoked shared routines and professionally prescribed rules for recovery as well as a high level of visibility and predictability in the 'doing' that was recovering for Ward A participants. Relations with the care staff were evoked most clearly through the 'first' stories. These relations appeared to be based upon a 'supportive abandonment' of the patients. The Ward B accounts on the other hand, lacked the 'rule-equipped' narrative of the Ward A participants. Instead there were stories of individual attempts to gain information from the health professionals to do with levels of rest and activity. These stories could also be described as representations of self-responsibility. From the accounts, clear-cut rules were not provided for the Ward B participants and this may not have been appropriate given the nature of the illness most participants had. The loose guidance 'do as much as you can' or 'use your common sense' was presented by several participants as unsatisfactory and worrying. Unlike the Ward A accounts, there was an absence of comparisons made between the participant's recovery and that of others in the same ward. This may have been because there were less patients undergoing the same specific surgery and/or there may have been, according to the accounts from Participants 1 and 3 (B), a lack of professional coherence concerning how recovery should be conducted.

## *Chapter 5*

# **'Recovery' and the framing of the experience**

### **Part 1: Recovery from surgery**

#### ***Section 1: From presentation of data to analysis.***

'Recovery' has meanings as a 'process' and as an 'end' condition. This analysis focuses upon the former for several reasons. The purpose of the study was to explore the 'experiencing' of recovery, or recuperation, from surgery. Interviewing took place during the experiential phase of recovering and not at a time distant from this. As already noted, (see description of methods), it was not possible to interview all the participants within the same time frame after discharge from hospital, so recovery talk was done upon a wide continuum of experiencing of the recovery process. Another reason for the main focus upon process, is that talking of ends was understandably difficult in the context of experiencing illness given the uncertainty of such situations. There is a notable lack of endings in narrative about illness (Hydén 1997). A further reason for concentrating upon the process of recovering came out of the researcher's perspective that as recovery involved some form of change, some sort of process would be uncovered. Finally, a focus upon process evolved within the analytical work itself through finding alignments in the study data with the situated learning theory of Lave and Wenger (1991). A particular 'trigger' to the identification of such alignments was the emphasis in this theory upon context. As already discussed, (see Chapter 2, Part3), 'context' was interpreted within situated learning theory in its widest sense, as being about not only the relations between people and their surroundings, but also to do with the relations of participation between people, in and across contexts. Conceptual links were made with sociocultural learning theory through the 'glimpses' that the representations, episodic narrative and stories gave of the experience of recovering. The nature of recovery as a learning experience was to be found in the participative or non-participative relations that were described, assumed or

left unsaid . Relations which were to do with the in situ recovery context of hospital and home as well as with the social world outside.

Analysis of the participants' representations of the recovery as a 'process' experience necessarily involved attending to both the form and the content of the accounts. The participants were asked in various ways, (depending upon how the conversation developed), to talk about their experience of recovery from surgery in hospital and when they went home. For example, what event made them think that they were beginning to recover?..... what has the experience of recovery been like to date?...how did it go?...all questions seeking to reach some sort of 'essence' of the process under study. These kinds of questions took time to design and sought to pursue a difficult concept rarely talked about in everyday conversation. The answers were given with much less time to prepare and so in most of the transcriptions they take the form of sense-making talk as if the person is actually working out an answer for herself as well as the interviewer. As a result, the answers often take the form of 'episodic narrative' (Reissman 1993) in which a theme or theory was begun, laid down awhile, and then developed further as the interview context moved on. The interviewer also took part to some extent in this activity with all that that may signify (Oakley 1981; Mishler 1986).

There were stories too, within this fragmented narrative which sometimes helped to identify the underlying rationale for the development of the whole narrative. In the first interviews from both groups, the story theme tended to be about previous surgical experiences the participants had had. The groups were similar again in the choice of the story line during the second interview, the experience of the hospital ward round being most often taken up. Examining the rationale or motive for the story telling, was assisted by a close inspection of form and thematic content and so of the social discourse which motivates and shapes the talk (Silverman 1993; Baruch 1981; Radley and Billig 1996). Discourse is a form of social practice (Fairclough 1991). Through discourse people construct an identity and a place for themselves and others in the world. At the same time the form and content of this language is shaped by the overall structure of relations between people and the system of ideas that exist within their society. 'Discourse is a practice not just of representing the world, but of signifying the world, constituting and

constructing the world in meaning' (Fairclough 1991, p64). Utilising this perspective something of the 'essence' of the process of recovery was sought.

In this analysis the portrayals of experience identified within the participants' accounts are explored further. The reflective and theorising activities that these portrayals contain are examined in relation to what they may reveal about the nature of 'recovery' as a learning experience. Lave and Wenger's (1991) sociocultural learning theory is an integral part of this analysis. As a consequence, how recovery experiences are contextualised or framed by the participants is addressed so as to ensure a focus upon the learning processes involved. Representations of responsibility are examined and related to the need for learner legitimacy. The context of learning is considered as it corresponds with accounts in which learning experiences are framed or unframed by rules and routines. Finally, the therapeutic narrative (Early, 1982) within the accounts is analysed with the aim of identifying what was learnt through the 'doing' practice of recovering.

### ***Section 2: 'Recovering' representations: A function focus.***

Being asked about the process of recovery generated a strong thematic similarity across the participants' talk. On a descriptive level, 'process' was talked about in terms of functional health. For example: Participant 1 (B) told of her attempts at walking distances; Participant 2 (B) explained that she made her family meals but delegated the washing-up; Participant 3 (A) was 'walking the dog'; and Participant 12 (A) was doing her own shopping. Even those participants who had not fared well in convalescence detailed their situation in terms of function- that which they could not do. For example, Participant 8 (A) reports being unable to walk without two sticks and Participant 16 (A) notes a continuing problem with climbing stairs. This theme of seeking to present individual functional recovery relates well with the work of Williams (1993) with rheumatoid arthritic sufferers which was discussed in Chapter 2, Part 1. Taking responsibility in some way for one's everyday living is displayed through representations of personal functioning.

Illness or health narrative, it has been suggested, is produced to make a particular point or to place the teller in a favourable light (Radley 1996; Hayden 1997). The surgical recovery period is a context in which the nature of the patient's experience lies on a continuum between health and ill health. What may have motivated the participants'

accounts of surgical rehabilitation will be examined. Participant 4 (A) tells the story of how she one day decided to attempt to do the laundry:

*R.....But as I say up until yesterday,...from coming home to that, I just didn't feel I had progressed at all. My walking hadn't seemed to improve, it still seemed pretty slow. But I got up yesterday morning and I thought, 'I'm going to have to get the day in' so I asked my husband to pull out the tumble dryer, ahh, which he did after I promised that if I felt it was too much, I would stop no matter, what stage the washing*

*FM Mmm*

*R.. was at, I would stop. However, it got done, as I say albeit that it took the whole day, ahh, and I felt better after that and I felt I had made another step forward*

*FM Mmm (4.2 p8) (A)*

This story was told after a narrative which had described the physical difficulties of the early weeks at home. The motive for telling this story, could have been to make clear to the investigator that Participant 4 (A) was making an effort and also to illustrate that she had reached some sort of turning point for the better. The story could be seen as a display of responsible action, making an effort to pull through the recovery period. It is mooted that the motivation for constructing a story of function being worked at, was to do with addressing morally imbued social constructs concerning convalescence. It is suggested that these constructs frame what is culturally acceptable behaviour for the recovering surgical patient. The functional thread to Participant 4's (A) recovery account seemed to have provided her with a way of plotting the course of her recovery experience. The power of this mode of portrayal was evident too when the interviewer used questions which in effect keyed in to and represented the functionalist discourse:

*R Ahhh, so saying, the first night home I dropped a pint of milk, which did not amuse my husband ahh, I've got one of those husbands that's not good about the house and doesn't know one end of a vacuum cleaner from the other sort of thing. Amm.....since coming home, the first few days...were terribly long, ahh, they kept telling me, you know you've got, if you're bending like am sitting it's to be a 90 degree angle, and I really got a mental block about this and*



*everything I was doing, I was stopping, 'Can I do that?' without going less than a 90 degree angle and I found the first two or three **days I tended to sit in this chair and I was, getting quite....frustrated, really** down, am, my daughter had taken a week's holiday and she was in*

*FM Mmhm*

*R..for a good part of the day, but after she went away, am...I was really quite down for the first few days, am, **gave myself a talking to and started to do bits and pieces about the house**, am. I find..*

*FM ((interrupts)) What can you manage? (4.2 p6 ) (A)*

The researcher seemed to collaborate with the participant in using 'functionalist' language, and this resulted in lengthy narrative concerning her physical abilities (see Chapter 4, Part 1). According to Hastrup (1992, p117) who was referring to the 'reality' of anthropological fieldwork, there is no such thing as an 'unmediated world of others' and what is really under study is the world **between** the researcher and the others. This dialogue between two world views has to be a characteristic of the results of research. Attaining physical function was what a right-minded responsible patient should be focused upon and those aspects of recuperation not directly linked to function are either not mentioned or given less value. Again Participant 4's talk (A) (cited in Chapter 4, Part 1) provides an illustration.

Her concern about using a walking frame was because it denoted a decrepitude which she could envision for herself. The cultural discourse which centres upon function moved into the conversation and served, it is suggested, to combat any impression the listener may have had that Participant 4 (A) was more taken up with less worthy thoughts. 'Function' talk had a socially legitimising function for Participant 4 (A). 'Being responsible' did not equate with the more cosmetic aspects of wellbeing and Participant 4 (A) took a self-deprecating line, calling her concern 'sheer vanity'. In dismissing her worry in such a way she was alluding to the socially less acceptable values she held about her appearance. A similar portrayal of responsibility was given by Participant 1(B) who also had cosmetic concerns over the appearance of her varicosed legs (Chapter 4, Part 1 for excerpt). She produced a credible profile as an agent of responsible patient behaviour by seeking surgery

with the expressed aim of avoiding the risk of what would ultimately be a functional deterioration. 'Function' again, was a marker, for the construction of a legitimising account of behaviour. Participant 1's (B) description of spoiled summer dressing alone would not have occupied the moral high ground.

After justifying her position as on the brink of surgery with its concomitant risk as well as the promise of improved function, Participant 1 (B), continued the risk theme in the recovering situation. This time the risk to function was told through a lengthy narrative of her everyday life recuperating which included quite a number of identifiable stories. For example, she told a story of her unsuccessful attempts, whilst in hospital, to learn the 'do's and don'ts' (1.2 p7, line 2) of recovery from medical and nursing staff. The narrative moved on to her home and the everyday details of, and her preoccupation with, knowing what were safe levels of activity and finding a pathway which promotes a healthy outcome and avoids complications. She introduced various people into her talk. These people were the ward sister, her GP, her step mother and her sons (1.2pp8-9). It could be argued, that the ward sister and the doctor gave witness to her attempts, albeit unsuccessful, at learning what was best to ensure a complication-free recovery. Her stepmother and her sons were cited so that they could be portrayed as acknowledging and witnessing 'worthy' attempts to be active and a good mother. Common to all these stories was Participant 1's (B) position as a 'doer', active in attempting to influence her recuperation. Radley and Billig (1996, p224) suggested that 'the study of health and illness is a study of activity.. (the) activity of accounting is performed by those struggling to claim themselves simultaneously to be both active and inactive' Lay knowledge of what was involved in recovering from varicose vein surgery was introduced into her account. Some of this knowledge was to do with being passive (resting her leg) and some was active (so much walking). Participant 1's (B) account could in fact be described as 'action-packed' given the narrative content to do with her attempts to glean information about safe practice for her convalescence as well as her energetic efforts to walk to the limits of comfort. The researcher suggests that such 'accounting for' activity, supported her representation of her convalescent activities as responsible and legitimate.

In summary, from the initial examination of the transcripts and the further analytical work concerned with the participants' representations of themselves, the dominant theme

was the presentation of self-responsibility. The way that this was done was through an emphasis upon function. The researcher suggests that the themes and topics which were taken up in such presentations such as ageing, 'self-infliction', cosmetic motives, pain, uncertainty, blame placing were introduced, modified or dismissed in the effort to place the presenter in the best light possible. More than that, it was to do with presenting a legitimate position, or a concurrence with the social discourses related to health and illness. Seeking such a concurrence however is no easy task given the complexity and sometimes contradictory nature of these discourses (Crawford 1993). The surgery may have been done and from a medical perspective, the symptoms of illness have been dealt with in some way, but the patient participants (particularly from Ward B) have to experience a convalescence from both their illness and the 'therapeutic injury' (Forrest et al 1985). Being asked to talk about this convalescence generated a good deal of sense-making and theorising work (Williams 1984; Stacey 1988) as to how to behave in a manner conducive to recovery.

## **Part 2: The framing of experience: rules of recovery**

### ***Section 1: In hospital and sharing***

It was Participant 1's (B) preoccupation with what she termed the 'do's and don'ts' of the recovery experience which sparked off a line of analysis which looked at the concept of 'rules of recovery'. Hammersley and Atkinson (1995) argued that study participants' concepts can contribute to the analytical development of research and this was the case with Participant 1's (B) account of her unsuccessful attempts to abstract from the care staff some rules of movement after her varicose vein surgery. Although no other patient took up the idea of there being a set of activity rules for the convalescent period with the fervour, detail or spontaneity that Participant 1 (B) gave, rules were evoked indirectly by other participants in the framing of their experiences. It is important to note that the evocation of rules was restricted almost completely to Ward A participants.

How this evocation was achieved was through the diachronicity of the narrative within their accounts (Bruner 1991, p6). Participant 11's (A) account (11.2 pp6-7) in particular, illustrated this narrative feature of conveying a sense of events happening over time (see excerpt in chapter 4, part 2). Her hospital experience was framed in terms of

specific days in which she underwent particular remobilisation activities as part of a routinised shared timetable. The diachronic structuring or framing of recovery experiences was a characteristic of all the Ward A accounts. Even Participant 9 (A), who had been eight weeks out of hospital, and in the main, had little to say about the hospital experience, always changing the focus of the conversation back to her present situation, produced, when prompted, a very time specific narrative which echoed the pace and progression of 11's (A) talk:

FM ..... And how did it go before you went out of hospital? I met you a couple of times, usually out on the pavilion bit, how did it go after your operation? How did the whole thing go for you after you'd had the operation? I remember you saying that you thought you would be a day in bed and then you would be [up the next

R [I was..... I had the operation on **the Wednesday**, we **were kept in bed on Thursday**. I think I was sick and then **on Friday**, we got up() to get up to begin with ( 9.2p6.123)(A)

FM Can you..it's a wee while now, it's about two months ago

R It's eight weeks on Wednesday aha

FM So can you remember, are you able to remember? When do you think you felt, started to feel better, started to feel things are going to work out?

R Ehh..

FM Can you remember?

R Well... I think by **the following Monday**. Well we'd had physio on the **Friday**

FM Aha, the first time

R The first time, we had physio on the Friday and we got boards, **the Saturday so we could keep our leg** going back and forward on the board

FM

R ...movement like that on the Saturday and Sunday and we got physio again on Monday and we got sticks on the Monday and I felt better once I'd got sticks

*FM How did you do with the sticks did it..?*

*R I had the zimmer to start with, but once you got in to the sticks, you know I think I felt a bit better. Em..I would say by the Monday I felt...I felt that I was going to make it...but I've still got this awfie pain in the back.. (9.2 p6.)(A)*

Despite the length of time since her discharge from hospital, Participant 9 (A) constructed a story of being exposed to a routine focused upon progressive ambulation. The process of her hospital recovery was remembered by her achievements, her physical effort. She presented an awareness of the potential failure and the riskiness of the experience. It was a recovery process captured by Participant 9(A) in naming the days of the week. Each day had a significance as bringing a new stage in her recovery.

Routinised progressive ambulation had within it specifically memorable high points, which provided material for story-telling. The main 'recovery milestone' elaborated upon was the 'first walk' in Ward A. What seems fairly probable from these 'first' stories was that there was a high level of first walk 'visibility'. The 'first walk' and other 'first' experiences (going to the toilet oneself; having a shower), were presented in a knowledgeable and intimate style of reference and suggested that there was some degree of sharing of one another's progress. From this it could be mooted that the framing of one's experience of recovery in Ward A would be assisted by being able to see others going through the same apparently time determined events. In other words, some degree of predictability may have characterised the recovery experience of that ward. With a predictability to the patterning of progress for patients comes opportunities for patients to share what they know of the framework of recovery. Roth (1963) described such a patient activity from his own participant observations in the context of hospitalization in TB sanatoriums. In the face of a protracted and uncertain length of time in hospital, and with the treatment regimen based upon time given for recovery or stages towards recovery, the patients imposed their own recovery classification system. What Roth terms 'timetables' were developed by the patients who sought to impose some degree of certainty and participation concerning their future recovery. For example, depending upon the diagnostically determined extent of the illness, the patients would predict how long they would be in hospital. The classification was built upon the observations the patients had

made about the treatment regimen which involved a series of activity restrictions and privileges. For example 'up time'-being allowed out of bed was a privilege which also signified progress. Such milestones, or what Roth termed 'benchmarks', were used by the TB patients in a mapping of what constituted a recovery framework. According to Roth (1963, p60), 'The clues the patients accumulate become a group product as a result of the constant discussion among patients about the timing of events and their treatment and hospital life'.

It is suggested that a group produced portrayal of the nature of the recovery process and the function of this portrayal, can be identified within the Ward A surgical patient participants' talk. The process experience of surgical recovery in Ward A was represented primarily as a shared experience and this sharing was mediated through personal experience and the observation of other's experiences of the ward rehabilitative procedures. The day-by-day scheduling of professionally prescribed events for the surgical orthopaedic patient featured strongly in the talk. There was a shared or communal thread through the talk related to these events which suggested that there was a high degree of procedural visibility in the ward. By this is meant that there was an emphasis upon planned professional interventions. Given the nature of the surgery, these interventions were activity based. Rehabilitative interventions which took place in the relatively small and open Nightingale ward were very likely to be observed by others. Instead of timetables engendered from observations of a treatment regimen based upon 'giving time' (i.e. time for the illness to resolve itself) as in the case of Roth's (1964) fellow TB sufferers, it was the rehabilitative routines aimed at remobilization that were alluded to in the recovery accounts of the study participants from Ward A.

The nature of the 'group product' from Ward A will be explored later in this chapter (Part 3). How such shared knowledge may have existed in this particular ward is not difficult to understand when the contextual details are reviewed: all patients were undergoing a small number of surgical procedures; there were specific highly visible schedules of activity for each form of surgery and the frequent opportunities to see others convalesce because operations were performed every weekday with new 'generations' of patients admitted to the ward. It was noted by the researcher that before the first interview on the day of admission all Ward A participants had made contact in some way or another,



with the established patient group. That there was a generational dimension to the experience of recovery in Ward A was 'glimpsed' in Participant 7's (A) account (see Chapter 4, Part 2, section 1 p107 for excerpt).

Of further interest in this account was the choice of the visible rehabilitative schedules as a way of answering a question about process. The experience of others provided information as to what progress was. Knowledge of what the recovery process consisted of was experienced by the individual and then reinforced by the observation of later generations going through the same surgical intervention. Participant 7 (A) also distinguished between routines for 'hips' and for 'knees', giving a glimpse perhaps, of the details which might be amassed into some kind of group produced knowledge specific to each type of surgical intervention undergone by patients. As well as suggesting that the nature of the experience involved opportunities to learn from the experience of other patients, the narrative content from two of the Ward A participants (Participants 7 and 11) provided a further insight into that shared experience. This narrative consisted of references to the experiences of other patients which appeared to be altruistically motivated. For example, Participant 7 (A) had been talking about recoveries in a general way and citing her husband's and her friends' experiences of surgery:

*R The ones who made the spectacular recovery were the people who'd had their hips done, that's you know, just sort of a couple of days later they're quite different. There was one girl who I got quite friendly with from -----she had a very bad limp and everything and then, as soon as she started to walk, oh her whole face, her whole demeanor, changed it was absolutely lovely you know she was a real, you know, example to everyone.*

*FM She had a lot of pain before?*

*R Yes, yes, the pain and the em, discomfort and she limped terribly, and an awful stick and heaven knows what. She wasn't that old only about fifty-five she said, and eh...by the time she went out oh she looked, you know, an absolutely different woman, it's absolutely amazing, yes, and so absolutely sort of thriving you know, it was lovely to see it and my husband was so pleased. You know you really felt it was great. (7.2 p12)(A)*

The visibility of recovery and the dramatic nature of some kinds of orthopaedic surgery recovery experiences was conveyed here. Sharing in this drama was acknowledged by Participant 7 (A) as a positive therapeutic experience for all who witnessed it.

However, all the participants introduced thus far had had recoveries which went, on the whole, 'according to plan' (Participant 7.2 (A)). Participants 16 and 8 from Ward A and Participant 6 from Ward B all gave accounts which 'glimpsed' at an altogether different framing of recovery. Interestingly, all these 'glimpses' were found in ward round stories. Participant 16 (A) responding to the research question to do with the nature of the process of recovery in hospital portrayed her experience of how her recovery process in hospital was represented by the health professionals (see Chapter 4, Part 2, section 1 p114 for excerpt). She theorised that the process of recovery was communicated by professionals through the changes in the dressings regimen. Recovery was framed within the narrow context of wound inspections. She implied a lack of interaction and participation with the professionals over these changes<sup>1</sup>.

Fox's findings and Participant 16's (A) account seem to be pieces of the same 'jigsaw' (Dingwall 1997,p62) giving an insight into the context and relations that may have constituted the surgical ward round in Ward A. This being the case, then it may have been no coincidence that Participant 8 (A) located her failure to recover within atrocity stories to do with her ward round experiences, past and present. The focus of these stories being her disagreement with the view that she was 'ready for discharge'.

Participant 6 (B), was quite distressed when she gave her ward round portrayal (see Chapter 4, Part1, p102 for excerpt). There is a marked similarity between this ward round portrayal and that of Participant 16's (A). Again the ward round was focused upon to convey a sense of process. Recovery was framed as a passive process in which the patient was given little opportunity to participate. There was an emphasis upon the relations between patient and health care professionals. Like Participant 16 (A), Participant 6 (B)

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<sup>1</sup> Some corroboration with this comes from Fox 's (1992) post-modern analysis of surgeons ward round behaviour. Attention to the wound was obviously important because of the danger of infection. However, Fox argued that the discourse associated with the wound inspection was also used as a distancing strategy by surgeons, one which prevented much in the way of patient input. He also posited from his observation of surgical ward rounds that wound discourse was used to signify progress and operative success and that it was significantly absent when discharge could be considered. 'Ready for discharge' being the ultimate marker of surgical success.

evoked a sense of patient solitariness due to a lack of interpersonal 'attending' (Participant 16.2) from the care staff.

Although not all the participants who had had a less than successful recovery talked about ward rounds, it is of note that that particular part of the hospital experience was used. The researcher conjectures that there may be several reasons for this. As an important occasion when assessments and decisions are made as to the process of recovery, it is likely to be part of a 'repertoire' of health setting contexts that the participants had to choose from. It may be that given their 'ritualistic' nature, (Fox 1993), ward rounds are not likely to be, on an interpersonal level, satisfactory experiences for patients. As such they may provide a context around which the participant can seek to make sense of and to complain about, her difficult or failed recovery (Silverman 1993). Ward round stories may also act as an obvious and convenient vehicle for the evocation of 'process' given the difficulty of answering questions about 'the nature of recovery'.

Of all the Ward B participants, Participant 3 alone provided some sense of what may have constituted 'rules' in the ward and only through some focused questioning (see Chapter 4, part 3). A 'do as much as you can' philosophy of rehabilitation was glimpsed. It was however, only in Ward A accounts, that the existence of ambulation routines or rules of recovery were glimpsed. That some sort of shared rehabilitative procedural experience was not evinced from Ward B patients would suggest that there was none to allude to. Or rather, none that was clear to the patient undergoing the experience. According to Dingwall (1997, p59):

'Whether of interest or not, (to the participant), the respondent is still concerned to bring the occasion off in a way that demonstrated his or her competence as a member of whatever community is involved by the interview topic'.

In the case of the Ward A participants, the glimpses or specific portrayals of rules followed as a shared experience may have been part of this 'demonstration' of competence. Recovery 'according to plan' (Participant 7 (A)) or even ahead of schedule (Participants 5, and 15 (A)) was described in terms of achievement within a specific group of people brought together to undergo a highly organised rehabilitation regimen. Competence as a member of this particular community was to do with process and with endings. Working

as hard or harder than everyone else and having a successful result, attaining a condition fit for discharge home were the kinds of competences evoked by the Ward A interviewees.

### ***Section 2: Home***

It has been suggested that Ward A participants accounted for their experience of recovery within a framework which reflected professionally organised prescriptions of rehabilitative behaviour during the stay in hospital and later for continued recovery at home. In portraying convalescence at home the talk of all the participants from Ward A was bounded by prescribed functional goals achieved or to aim for. There was much to say about how everyday life was managed according to the rules of movement given by health professionals. Participant 15's (A) home interview is a good example of a 'rule-equipped narrative'. This was evident from the very beginning with Participant 15 (A) talking about her stay in hospital, when the rules related to a highly organised recovery routine in which she had rules of activity applied to her, to later when she described her recovery at home and her careful adherence to professionally prescribed 'do's and don'ts' (see Chapter 4, Part 3, section 1 p121). The 'conveyor belt' experience (Participant 11 (A)) was given, one could posit, the pace and concentration upon the restoration of function that was the Ward A rehabilitation regimen. At the very beginning of her narrative Participant 15 (A) introduced the educational influence of the professionals in the context of making clear that she was adhering to instruction (see Chapter 4, Part 3 p122 for excerpt).

Life at home was about 'managing' and that was achieved by seeking to adhere to specific rules of movement. Within this rule-laden representation there was, not unexpectedly, the measurement of progress against an official yardstick with Participant 15 (A) presenting her success at getting home earlier than the official estimated discharge date (15.2 p4). It has already been noted that she may not have been comfortable with or held a different perspective as to the concept of interviews and being interviewed about her experiences (see Chapter 4 Part 3). A close adherence to rehabilitative training instituted by the carers of Participant 15 (A), may result in specific knowledge gaps. It is of note that a patient, who had experienced a rehabilitative hospital routine which appeared to have been very function and time oriented, sought answers to do with the timing of her progression towards recovery. Participant 15 (A) had two questions concerning the

recovery process and when milestones, such as abandoning two stick walking or alignment cushion positioning, had been reached. She was not alone, Participant 5's (A) narrative suggested that she needed professional 'permission' to progress:

*R...as I say, I had a check up yesterday...they're very pleased and now, keep the zimmer handy, but use the stick as much as I can, which comes in very well because I was going to ask them anyway if they would approve of people picking me up at the house to take me out and could I use a stick to get from the house to the car.. (5.2 p7) (A)*

Baker (1989) in her study of how cholecystectomy patients experienced the process of recovery identified a need for health professionals to provide more details as to the pacing of activity resumption. According to Baker, surgical patients need more information to do with safe levels of mobility. Participant 11's (A) narrative provides some hint as to why some of the Ward A participants had been unsure as to their progress:

*R...and that's one thing during the week we were given all the things you must not do*

*FM Right*

*R You mustn't bend this leg, you mustn't....there was a list of things....keep your legs together every time you move them...getting into bed at night, lift your leg*

*FM Have you to do this all day or just in the meantime?*

*R When I remember and when I don't remember you know all about it because there is still this, whatever it is embedded in cement or something...I don't know...you feel it's there if you do something...you **shouldn't** pick anything up but if you have to stretch that leg out **don't** bend it....(11.2 p8) (A)*

There may have been a professional emphasis upon making sure the patients knew what not to do so as to ensure safe levels of mobility. To some extent this emphasis is understandable as a way of preventing damage to the surgical work and the physical healing process. It should also be recognised that rehabilitative advice about what one can't do is easier to give and to adhere to, than that about what one 'can do'. However the

latter knowledge is surely needed for an experience of 'process' such as recovering. This seems to be borne out by Participant 15's (A) dilemma at home where there could be no professional supervision of the 'can do' activities for patients (except by telephone) and from her account, she appeared ill-equipped to deal with decisions relating to how and when to move on. According to Olszewski and Jones (1998), professional research has been concerned in the main, with the delivery of knowledge and not with the experiences of the recovering patient. In relation to Participant 15's (A) report of her situation, 'delivered knowledge' has been weighted toward the 'don't' as opposed to the 'do'sort. This study has been concerned with the experiences of recovering and in Part 3 of this chapter, what experiential knowledge may have been gained by the participants will be explored.

In summary, within the WardA participants' accounts there was a shared or communal thread which related to the day-to-day scheduling of the ward rehabilitative routines. This suggested a high degree of procedural visibility by which patients were able to observe other patients' experiences. As a consequence, the possibility was suggested that there was a knowledge pool amongst the patients relating to a framework of rules of recovering in hospital, which was passed on to new 'generations' of patients undergoing specific surgeries. It was also posited that the participants from Ward A, having been given a way of framing their experience had used the professional prescriptions as a way of representing their experience. It was noted that the Ward B accounts were not 'rule-equipped'. The 'exceptions' from the Ward A sample provided insights as to less positive perspectives concerning the ward recovery routine. In particular in relation to patient perception of support from health professionals and the way that nurses and doctors are placed or represented within the routinized recovery schedule of Ward A. In considering how the recovery at home was framed, there was a emphasis upon describing recovery in terms of what was, and what was not being done. It was noted that for some of the participants, recognising when to move on in one's recovery may be a problem, whilst others presented their own 'milestones' in terms of regained function.

### **Part 3: What was learnt of recovery?**

This part of the analysis addresses what the participants' accounts revealed concerning what experiential recovery knowledge was gained by surgical patients from Wards A and B. Therapeutic narrative, Early (1982) argued, functions as a ritualistic way



to work out the rationale for actions that were taken and to 'endorse a state of affairs'. It is posited that looking at the sort of therapeutic narrative the participants produced in response to questions about 'what helped', may provide some insight concerning what was learnt through 'doing'.

### ***Section 1: Learning and the Ward A accounts***

Participant 11's A) account provides an illustration of the nature of the therapeutic narrative that the Ward A participants gave when asked about what or who helped them with their recovery experience ( see Chapter 4, Part 2, section 1 pp106-107 for excerpt). Participant 11's (A) narrative evoked a system of organised care based upon a temporally dominated routine. The 'conveyor belt system' of Ward A was expounded and endorsed as promoting individual recovery. There was also approbation of what could be described as a 'supportive abandonment' of the patients by the care staff. By this is meant that patients, were pointed in the right direction and expected to get moving. 'Supportive abandonment' was mainly evoked within the 'first walk' stories. Like Participant 11(A), Participant 5 (A) presented a time scheduled remobilisation, validating it as confidence engendering: 'You had freedom to encourage yourself....to do things...and move about' (5.2 p9). Apart from such presentations of individual experience, the presence and experience of others was a dominant feature of the Ward A accounts. In addition to learning the significance of time as a measure of successful recovering in Ward A, the researcher suggests that this access to other's experience may have resulted in the building of the 'group product' described by Roth (1963). Participant 7's narrative supports this view where she posited a 'doing okay' gauge which was directly linked to whether she was able to 'follow the routine'. The presence of an identifiable 'routine' then may contribute to a shared knowledge of recovery amongst the patients of Ward A. Plath (1963) portrayed a similar shared knowledge or 'group product' amongst psychiatric patients generated in relation to the levels of madness associated with being placed in particular wards within a psychiatric hospital. The 'routine' may have helped in the acquisition of practical knowledge in that it provides 'rules of practice', the rules being the 'relations between prescriptions' promulgated by the care professionals (Carr 1981, p60). As part of a social context that consists of relations and expectations that are always fluid and subject to change, the 'routine' is likely to have influenced the participants' knowledge of

recovery. The routine of the orthopaedic ward as it is presented in the participant accounts is insightful as to what 'recovery knowledge' is, as well as how it is learned. In the accounts there were two main portrayals of the ward routine and its influence upon individual participants. One sort of portrayal took the form of participant theorising. This consisted of the attempts made by the participants to explain their recovery or 'doing' experience in terms of the routine, for example, a 'conveyor belt system' (Participant 11) (A) or a 'supportive atmosphere' (Participant 7) (A) or goal-setting (Participant 4) (A). The second kind of portrayal was centred within the routine in narrative which glimpsed at the complexity of social relations experienced by participants. Examples from the accounts of these relations include Participant 7's (A) story of what happened when she didn't comply with specific rules of movement:

*R Yes, yes, and at times at night, it would be quite nice to be on your own but, but eh, generally speaking, you know, the, the and they answered the bell right away, you know the staff were great yes. And the day I walked, I was told to walk down and get my lunch in the day-room and eh, I hadn't put this..er what do you call it? ..splint thing on again and one of the staff came up and told me, in a nice way sort of told me off ..very..but..I mean I hadn't realised how important it was to put it on, you see and 'don't for goodness sake walk without it again' you know but he didn't tell me off in front of everyone, he was just.. just made sure I realised ..yes and I em.. (7.2 p10)(A)*

In this excerpt there is reference to a variety of relations which are contextualised by the participant within the routine. This single one-to-one interaction portrayed between the nurse and the patient amounts to a much more complex scenario. The patient has been given instructions to go and get her lunch on the day she 'walked'. There is an evocation of performance and by implication, of audience, from the outset, and then the nurse approaches and the presence of an audience is made clear in Participant 7's (A) description in which she is at pains to elaborate upon the nurse's behaviour as being cognisant of 'being in front of everyone'. Interpreting this scenario from Lave and Wenger's (1991) sociocultural learning perspective, the interplay of relations evoked, corresponds on several levels with the idea that learning takes place in a 'participation framework' (Hanks 1991). The routine of Ward A seemed to provide a practice 'window' for the patients in the 'local'

context of the orthopaedic ward as well as across contexts into, in the instance of this study, the social context of the research interview. At the local level the reported behaviour of the nurse could be interpreted as protecting the 'legitimacy' of Participant 7 (A) in her learning the correct way to ambulate, and at the same time, in intervening in the practice of individual and 'audience' in a way that is affirming of the individual and mindful of the other patients who participate on the periphery of that individual's practice. It can be argued that looking at the routine as a window between social contexts is of pertinence too in addressing what was learned of recovering. Participant 7's (A) therapeutic narrative was in itself, likely to be an example of the transformative nature of participation in everyday life, in this instance responding to research questions (Lave 1993). In other words, what she learned of her recovery changed as she talked about it. It could be conjectured that the routine may have facilitated Participant 7, the learner, access to the complex interrelations within her past situation of recovering and that of the later context of the interview. An interview context in which the meanings and perspectives implicit in the researcher's questions about 'what helped' would become part of an ongoing learning process.

According to Bourdieu (1990), asking questions aimed at getting the participant's view of his/her 'doing' of recovery would be to risk losing the essential nature of that practice through 'theorization'. The main way that the Ward A participants gave a structured description of their recovery practice was through use of the remobilisation routine. In such presentations there was an element of familiarity with the routine assumed of the researcher, by the participants. To some extent then, the 'routine narrative' held a 'language of familiarity' which revealed something of the essence of the knowledge of recovery. Glimpses of the temporal, function-oriented, prescriptive, comparative and shared characteristics of the relations within a participation framework for recovery learning have been identified in the accounts. Mindful of the need to value the exceptions or deviant cases in the data (Silverman 1993; Hammersley and Atkinson 1995), it may be of significance that the account which did not evoke the routine was from the one participant who had had unsuccessful surgery and a resultant poor physical recovery (Participant 8)(A). Further, in her account Participant 8 (A) made no allusion to the presence of other patients. What she did talk about was her medical ward round

experiences. It has been suggested (see Chapter 4, Part 2, section1) that her telling ward round stories enabled her to present a participative presence in her account. It can only be conjectured that because of the failed surgery, Participant 8 (A) was not given access to the usual rehabilitative schedules as she would have been unable to 'follow the routine'. This was a form of non-participative practice and therefore, according to Wenger (1990), non-membership of a community of practice which was focused upon a future of recovery. It is suggested that just as those participants who had had a successful physical recovery, may have developed their knowledge of recovery further in the interview context, Participant 8's (A) portrayal of the attentive efforts of her daughter, her friend and the GP (p5 of transcript) was a 'glimpse' at her experiential learning experience of the struggle to rally in response to a regimen of love and care.

Sprinkled through the therapeutic narrative of the Ward A participants were references to the specific 'how to' rules of movement (Carr 1981) which were provided by the health professionals. How such rules may have influenced the practice experience of recovering was 'glimpsed' in Participant 4's (A) story of her early days at home when she had to stop and think through how she should position and move herself in a way that would ensure the integrity of her hip replacement:

*R..ahh, they kept telling me, you know you've got, if you're bending like am sitting, it's to be a ninety degree angle, and I really got a mental block about this and everything I was doing, I was stopping, 'Can I do that?' without going less than a ninety degree angle .. (4.2. p7)(A)*

On the other hand, there were 'glimpses' of applied learning which seem to have originated in the individual participant's 'doing' of recovery work and not from professional prescriptions. This could be seen in Participant 7's (A) description of her attempts at home to work out what were appropriate levels of activity and rest in which she theorised about the need to 'learn to pace yourself' (7.2 p14). Participant 1 from Ward B gave a very similar presentation of her efforts and concerns about what constituted 'not overdoing it' (1.2. p9).

What seems to distinguish the Ward A participants' accounts was the presence of narrative about 'doing' recovery that was characterised by an underlying assumption of a

healthy future. In addition, there was frequent accessing of knowledge from a variety of sources, the routine being the 'window' for much of the ward-based learning to 'do'. In both sets of accounts 'doing recovery' seemed to involve working out how to pace oneself by 'body listening' as to how far one could push oneself.

### ***Section 2: Learning and the Ward B accounts.***

In the case of the Ward B accounts, trying to establish what may have been learnt of recovery, through asking questions concerned with 'what helped?' was a different task from the analysis of the Ward A accounts. Further, Participant 1(B), mainly through her stories of her encounters with the nursing staff, identified at some length what did **not** help recovery. Her portrayal of her attempts to wrest from the health professionals, specific rules or 'do's and don'ts' for a safe, successful recovery, seemed to suggest a lack of institutional initiated structures which would have provided Ward B with the cultural transparency necessary for legitimate peripheral participation (Wenger, 1990). The absence of rules and routines from the Ward B accounts was accompanied by less allusion or specific reference to 'others'. As a consequence, from a sociocultural learning perspective, the participative framework of social relations which facilitates the access of the learner/patient to learning experiences was not 'glimpsed' in the accounts. There were exceptions (the accounts of Participants 6, 12, and 18) in which although there was no reference to rules or routines, there were references to the individual's relations with other patients in the ward. However, in the case of Participant 6 and Participant 12, these relations were unhappy ones (see Chapter 4). Contrasted with the Participant 8 and 12 accounts, was a brief 'glimpse' from Participant 18 of more positive relations between patients in Ward B. Participant 18 had been describing a chance meeting in the out-patient clinic with one of the patients she had known in the ward :

*R So I met her and she's still in quite a bit of a state actually, ...But she said to me, 'Oh', she said, 'It was a lovely ward, but when you had gone' she said, 'we didn't have the laughs' But it was just nerves with me, you know, have a laugh at night when we were all in bed I'd pop up and say something and have them all in stitches. But I'm no really a funny person, I think it's just that I'm wound up like that, I've got to keep at it and try and get out of the mind sort of thing. (18.2 p8)(B)*

Unlike Participant 12's (B) account, relations with other patients in Ward B were portrayed, albeit fleetingly, as supportive. This vignette lends weight to the theory that weaker relationships can contribute to individual well-being (Adelman et al 1987), and, in addition, that the recognition of such helpful relations, such as Participant 18's joking, may in itself be therapeutic (Hinds and Moyer 1997). However, if anything can be extrapolated from these three accounts and those of the other Ward B participants, it is that, like Dewis's (1989) spinal cord injured inpatients, social relations amongst patients within the ward were more likely to be selective in nature because of the anxiety arising from seeing others in a more deteriorated state than themselves with the same progressive illness. The apparent lack of any other institutional structures in place, of rules and routines which would promote the development of a shared knowledge of the 'doing' of recovery suggests that opportunities for learning to recover were few.

What was learned may relate to a previously mentioned account from the Ward A participant group. Devoid of any narrative to do with a ward routine, Participant 8's (A) narrative was about her 'doing' a fight for survival within which regaining the will to live constituted an important part. An 'invisible' emotional work was identified in the accounts of the Ward B participants (Strauss et al 1985). Participant 18's (B) stoicism in relation to the changes in her everyday life, Participant 6's (B) obvious distress and anger at her post-discharge complication and Participant 12's (B) lengthy sense-making work concerning the causes of her amputation have already been highlighted (see Chapter 4). Coming to terms with the uncertainties of peripheral vascular disease can be seen as constituting a process of learning but one which, it would appear, was not supported by the institutional structures of the ward. The admissions of 'guilt' from some Ward B participants to having been cigarette smokers have already been noted (Chapter 4). Such self-denigration activity may be revealing about these participants' relations within the contexts of the interview process, the outside world and the social world of Ward B. Jeffrey's (1979) study of casualty departments may be of pertinence concerning this activity. The views held by casualty staff towards a range of patients admitted were found to be morally imbued with the idea that there were patients who were more or less 'deserving' of their attentions. An instance of this behaviour which was particularly illuminating was when the usually hostile



position taken by the health care staff towards attempted suicide cases was greatly softened towards one 'suicide' who owned to having thought the better of his actions and got himself to hospital. Presenting themselves as 'to blame' for their condition may have been related to positions taken by Ward B care staff operating in an institutional structure based upon the acute medical model of care (Latimer 1997) and within a society in which health and illness is frequently viewed as potentially very much down to how the individual lives his or her life (Crawford 1993).

From a sociocultural learning perspective (Wenger 1990), it could be hypothesised that learning of 'recovery' in Ward B, would be a limited learning experience because there was no apparent framework for participation within the ward. For any framework to exist there needed to be rules or common understandings for practice in relation with others. Advice such as 'do as much as you can' or 'use your common sense' (see Chapter 4), lacked the relational underpinnings of routines and 'do's and don'ts'. It may have been no coincidence then, that any insights, spontaneously given concerning recovering experiences for the Ward B group of participants came when the accounts switched to the context of home. At home the expectations and activities of self and of significant others were made evident in the Ward B participant accounts. Frameworks for practising recovery could be gleaned for example, in the narrative from Participant 18 (B) in which she works at trying to 'thole' (see Chapter 6) the boredom and loss of freedom due to the need to rest her leg whilst her husband 'worries' and takes over much of the day-to-day household responsibilities and the caring for her. A similar narrative content came from Participant 3 (B). Further, it can be argued that in Participant 12's (B) 'shoe story' lies an ongoing participative framework linking past, present and future rehabilitative learning.

In summary, within the Ward A accounts experiential recovery learning was identified in the framing of experience around and within the re-mobilisation routine. This framing was temporally structured with milestones or eras which provided a transparency to the experience of 'doing' recovery. It could also be said that the routine was a practice 'window' across the social contexts of past hospital experience and the research interview because the learning experience was made more accessible in the telling to both study participant and the researcher. It would seem possible then, that accounts of recovery can contribute to an understanding of the patient's practical learning, on the premise that

participative frameworks can be located within the narratives. Equally, when such frameworks cannot be located or are relatively 'opaque' (Wenger 1990), within the doer's account, as they were in the case of the Ward B participants, it is possible that something can be said about the lack of opportunities for experiential and applied learning.

## *Chapter 6*

# **Learning and accounts of recovery**

With hindsight, built into the research design was the assumption that, by asking any patient about their surgical recovery experience, no matter the type of surgery they were to undergo, would result in answers about 'recovery' as a distinct entity. Particular characteristics could be abstracted from this entity which could perhaps be generalised to all kinds of surgical recuperation. In retrospect this perspective sought to separate 'recovery' as a process from the context in which it was expected to take place. The accounts from the Ward A sample, were most obviously placed in a distinctive context by the participants themselves. The presence of this characteristic of the accounts from the Ward A participant group and its relative absence from those of the Ward B group, prompted the researcher to rethink the concept of context.

Although various themes were stimulated by an analysis of the transcriptions, it was the representation of a shared travail towards recovery displayed by the Ward A participants, which most intrigued the researcher. Her interest was further fuelled by the discovery that no such representation was evident from a comparative analysis of the interviews with the Ward B participants. Questions aimed at encouraging surgical patients to talk about their **individual** experience of the process of recovery had generated 'glimpses' of sharedness predominantly from the Ward A participants. As well as these communications of a contextual 'reality', some patients appeared to 'account for' their progress towards health in terms of a communal experience within Ward A. Whatever recovery processes took place for either set of participants, involved some sort of change experience. An explanation for the presence or the absence of 'sharedness' accounts needs to involve an examination of what sorts of learning experiences may have been taking place. Further, the possible reasons for the marked difference in the

contextualisation of these experiences by the participants, needs to be explored as does the question of how this difference may provide another perspective of recovery.

At the proposal stage of this research the investigator had little idea as to what patients would say about what helped them with their recovery. If any preconceptions were harboured, they were to do with finding particular therapeutic and /or educational one-to-one relationships with health care staff which worked for the patient. That no such relationships bar one (Participant 11, Ward A) were alluded to by any of the participants was a surprise. In the case of the Ward A group, health professionals were evident in participants' narrative but in a manner which embedded their influence within a much broader and complex context - a context in which the presence of the other patients was communicated implicitly and explicitly. The context of the Ward B accounts, on the other hand, was more elusive. It seemed to the researcher, that in seeking possible explanations for the differences in the accounting activity of the participants, there was an opportunity to explore at length issues of social context. This will be approached through the analytical perspective which defines learning as legitimate peripheral participation (Lave and Wenger, 1991).

From this perspective the way that people develop and change is to do with participating in ongoing practical activity within a socially constructed world. 'Legitimate peripheral participation' is 'a descriptor of engagement in social practice that entails learning as an integral constituent' (Lave and Wenger, 1991, p35). This learning it is argued, does not take place in a vacuum, but in social settings which consist of sets of relations between people involved in practical action. From this perspective the context for learning (in other words, the practical actions involved in recovering from surgery), is a complex matrix of relations between the individual and the activity or work and others who are active in the situation. The 'others' importantly, are likely to include those who are not new to the activity. Learning then is a social experience. It is a process of increasing participation in 'communities of practice' from a position of peripheral activity towards one of increasing participation and membership. The researcher's initial surprise and curiosity as to the marked difference between the two sets of accounts in relation to the discovery of evocations of a 'shared travail' had sparked an interest in looking at the accounts in terms of 'community'. At first, what the researcher had meant by

'community' was solely on a descriptive level to do with noting evidence of some sort of affiliation between the patients in the ward. However, with the adoption of the sociocultural theory of learning, the meaning of 'community' became more complex. According to the sociocultural learning theory of Lave and Wenger (1991), the existence of a 'community of practice' within which 'knowledge' could be accessed, was the rationale for legitimate peripheral participative activity. In relation to the focus of this study, the knowledge gained in communities of practice was not only, for example, specific 'ways to move', but to do with ways in which to interpret and understand that practice activity. For example, the nature of power relations between physiotherapist and doctor may provide the patient with a particular way of viewing what constitutes physical progression. Further, that is but one relationship situated within the complex matrix of social relations experienced in the care setting.

In addressing the possible reasons why there are accounts of communality in only one set of participants it is not simply a question of seeking a relationship between a patient's actions and the ward environment but to look for the 'relationships between local practices that contextualise the ways people act together, both in and across contexts' (Lave, 1993 p22). From this view context is not an entity which can be separated out from the recovering experiences glimpsed in participants' accounts. Context is integral to these experiences. Indeed the accounts themselves could be seen as extensions of this context given their possible functions as displays of membership and as part of an ongoing sense-making activity. The presence and absence of communal evocations has provoked the idea of the process of recovery as involving a form of legitimate peripheral participation and explanations for the difference in accounting activity will be pursued using this social and cultural learning perspective.

The research interview situation itself was another context in which relations between interviewer and interviewee and between past contextual relations and understandings, may have resulted in further learning for both. For the researcher, certainly, ongoing learning was discerned particularly during the process of interpretation of the interview transcriptions. 'Context', seemed increasingly to become an extended concept in the reflections of the researcher. The boundary between what was past knowledge of the researcher (drawn from a variety of experiences as a clinical nurse and nurse teacher in

orthopaedic and peripheral vascular units) and what was the participants' portrayals of their experiences, became blurred. This, it is mooted, was to do with an articulation between the two sets of contextual relations which resulted in a change or development in the researcher's understanding. The upshot of this was to 'discover' further areas of contextual comparison. To illuminate the later discussion, these areas will be elaborated upon now.

### **Part 1: The orthopaedic ward and the peripheral vascular ward: further contextual comparisons**

All but one of both sets of participants had been admitted for some sort of leg surgery. There the similarity ended as the nature of the conditions and the forms of surgery undergone made for very different contexts for the participants. Ward A patients were usually elective patients from a long term waiting list with most having waited six months or more for notification of their imminent admission to hospital. The week before coming in for their surgery most of these patients were invited to a pre-admission clinic. The 'elective' history of the patients of Ward B was of a very different character. The wait for admission was much shorter but it was likely to have been the sequel to an earlier emergency or investigative admission to the ward.

For Ward A patients there was less likely to have been previous surgery for the complaint unless the scheduled surgery was to replace a prosthesis inserted usually many years previously. The scenario was very different for B participants. Due to the progressive nature of peripheral vascular disease, they may have had or had expected to have a long, continuous history with Ward B (once acquainted with the experiences of other patients in the ward). A further, perhaps more critical distinction between the sets of patients was that the progressive character of PVD frequently entailed lengthy periods of pain, disability, and sometimes a threat to life. Because of the character of the conditions that the participants had, the requirement for and the goals of the surgery were generally dissimilar. Surgical intervention for Ward A patients was aimed principally at restoring joint function, while for B patients it was primarily undertaken to save or amputate a limb. The goal of the orthopaedic surgery was curative in the sense that a new hip or knee rejuvenated, released and broadened the life of the patient. Peripheral vascular surgery on



the other hand, due to the chronicity of the disease, has a palliative function, with perhaps less dramatic improvements in the patient's situation.

In seeking explanations for the differences in the participants' accounting activity, attention to how the specific context of surgical intervention may influence relations between people is necessary. As already proposed, the search for explanations will be discussed employing the ideas of sociocultural learning theory with more of the contextual 'backdrop' now in place.

## **Part 2: Representations of support and 'glimpses' of structures for participation**

### ***Section 1: Ward A***

It can be argued that, in the case of Ward A, 'support' was presented in the form of a portrayal of communality. This communality or support was evoked in a variety of ways. One form of this was the narration concerning other patients' present and past experiences, for example, Participant 7's (A) narrative concerning the dramatic improvement in capability and in the whole demeanor of a fellow patient. It seemed clear that there was some degree of networking amongst the patients of Ward A. Access to other patients was facilitated most obviously in geographical terms. Like Marshall's (1972) apprentice butchers going to the trade school, the participants had a means of observing the recovery practice of others. From the accounts there were 'glimpses' of an access to a heterogeneity of experience (Lave and Wenger 1991). The ward patient peer group had within it a continuum of past, present and possible future practice experience of what 'recovering' was. It was then a recovery practice experience which was chronologically heterogenous in character. Different patients at different stages in the process of recovery were highly visible to the participants from Ward A. Here, it can be argued, was a contextual structure for participation in the learning that was involved in recovering. Like the trade school there were people in the ward with different levels of skill, in this case, of mobility and independence. In addition, the specific chronological scheduling of patient recovery would perhaps have provided a further opportunity to differentiate more easily, the qualitative difference in skills between the 'apprentices'. Other patients' and one's own performances could be normatively assessed in relation to this scheduling.

As well as a heterogeneity of experience within the ward's patient population, there were different locations and events and relations structured into the orthopaedic patient's hospital 'career'. From the time of the pre-admission clinic the Ward A patients were in contact with a variety of health professionals. Each of these contacts had an interlocking purpose with all the others, in completing the investigative and information-gathering activities of the care staff. Each clinic-based professional contact was also distinctively different. The evidence of a highly, regimented unvarying process, for each patient going through processing system, belied the complexity of difference in the relations between the pre-admission patients and different professionals with whom they had formal or informal contact.

Deeper contextual layers seemed to involve a heterogeneity of expectations and orientations conveyed during the patient-professional interviews. For example the orientation of the nurse was to preliminary information gathering which was to do with ascertaining the general details about the patient, while the physiotherapist carried out an assessment process specifically concerned with limb function. In the case of the latter there appeared to be the beginning of a working relationship with the new patient. In contrast to the clinic based nurse, the physiotherapist was very likely to have further contact with the patient at ward level. It could be speculated that the social relations between the patient and these two kinds of health professionals would be quite different in part because of the presence or absence of expectations of future contact. With exposure and participation in the different orientations and assumptions of relevance presented by members of the multidisciplinary team, a heterogeneity of experience concerned with recovery from surgery, had already begun for the patients of Ward A. It should be remembered that apart from the interviews with professionals the pre-admission patients' had to demonstrate their present joint function; had investigative procedures carried out and were given access to literature to do with their surgery and recovery and to the company of other people awaiting similar surgery. Indeed it is suggested that the clinic was perhaps a particularly effective learning context because of the breadth and complexity of the situated activity which went on there.

The influential role of the physiotherapists in enabling patient participation in situated recovery learning was likely to have been additionally emphasised by the organised,

regular visits to the physiotherapy department and the taking part in the small group ‘do’s and don’ts’ teaching session held in the ward on a weekly basis. Participant 4 presented her view of the relatively powerful role of the physiotherapists in the manner of one communicating a widely held belief. Physiotherapists were depicted as instigators and supervisors of hard, painful, but necessary remobilization exercises. They were given recognition as very influential in the discharge decision-making (Participant 8) (A). A glimpse of one facet to the physiotherapist and the patient relationship was the negotiative activity, (Participant 16) (A), concerning the achievement of an appropriate knee extension angle prior to discharge. Within the accounts, narratives concerning the piece of equipment called the ‘mobiliser’ seemed to be related to representations of participation in one’s own recovery. There is a parallel in Roth’s (1963) description of his patient peers’ attempts to come to a mutually agreed time for discharge.

Further structures for participation in the practice of ‘recovering’ relate to the stories about particular milestones in the recovery process in hospital. These stories were mainly to do with first time experiences which appeared to be part of routinised recovery schedules. Portrayals which gave ‘glimpses’ of the existence of such schedules, also provided some insight as to the possible context of relations that the patients had with the nurses in these experiences. These ‘glimpses’ were found in narrative which conveyed an impression of particular ‘rites de passage’ experiences to do with functional progress, which was orchestrated and supported in particular ways by the nursing staff. This is exemplified in Participant 11’s (A) story of her struggle out of depression and helplessness in the early days post-surgery in which she cited the forceful support of a male staff nurse leading up to her first steps post-surgery. The researcher posits that the relations between patient and nurse in Ward A may have parallels with Latimer’s (1997) findings that nurses can be involved in ‘moving’ patients on towards discharge. It is suggested from the accounts, that the existence and nature of the routine in itself communicated to the individual participants expectations of progression. This was most clearly communicated by Participant 7 (A) who talked of herself and the other patients in the ward as recovering ‘according to plan’ and by Participant 4 (A) who once home and without the routine talked of her sense of stymied progress.

It seemed to be in the everyday tasks of mobility that particular relations of 'supportive abandonment' existed between patients and nursing staff. By this is meant that there were particular events in the everyday recovery process which patients identified as significant and at those times the nurses having instigated the event, left the scene. In general, relatively little of specific nurse-patient relationships were glimpsed from the patients' accounts. It is suggested that this may have been to do with the everyday nature of these relations (Wilson-Barnett 1988a). The significance of the everyday relations between the patient and the nurses perhaps were not easily discernable to the individual participants. What was discernable, of course, was their own and other patients highly structured, highly visible recovery 'trajectories' (Strauss et al 1985). These trajectories that were organised and presented through rehabilitative schedules managed on a day-to-day basis by the nurses. The relations of support generated from this scheduling have already been dwelt upon in connection with access to a heterogeneity of patient experience. It is speculated that the relations of support patients had with nurses were inextricably linked to the operation of the rehabilitative routine. This speculation is supported by the following illustrations. The 'supportive' actions of the staff nurse portrayed by Participant 11 (A) could be interpreted as gentle persuasion to adhere to a timetable of graduated activity. Participant 7's (A) comment about recovering 'according to plan' also gave a glimpse of possible relations between the care staff and the patients which seemed to involve the routine as the means to communicate the staff expectations of patient performance. At the same time, reference by the study participants to the routine within the accounts, may have served to display the participants' participative activity in Ward A.

A particular facet to this timetabling of recovery, which was conveyed strongly by the Ward A participants was a tying of stages or new phases of the recuperative experience in hospital to specific days post-operatively. No doubt 'in reality' there was flexibility in the orchestrated progression of patients through the 'conveyor belt' system (Participant 11) (A). However, it has already been noted that a particular feature of the Ward A narratives, was their diachronicity. This narrative feature may shed further light upon the form of structured participation initiated by the health professionals in that this perspective of time has been associated with particularly Western societies. In this conceptualisation, time takes an open and progressive form (Roth 1963; Adam 1990). In other words, time is an

experience of movement forward. It seems likely that the ward's rehabilitative approach 'fitted' well generally with the Scottish cultural construction of time. It is mooted that such an alignment of time perspective must have made for greater homogeneity of purpose between staff and patients, as well as making the experience of recovery in hospital more congenial to patients socialised to perceiving the passing of time in progressive terms. Perhaps the evocations of 'communality' from Ward A, stem ultimately from such an experience of shared purpose. It is also suggested that for the new patient having participative structures which reflected the outside society's cultural mores of how time should be experienced, would have made those structures more visible.

It has been mooted that the participants' accounts were not only representations of some sort of community, but also of belonging to that community. It was a distinctive characteristic of the accounts from Ward A that processes of recovering were evoked. There were portrayals of patients in action and health professionals engaged with that action. 'Belonging' was also portrayed in distinctively functional terms. Aside from what might have motivated participants to represent themselves as part of the communality of Ward A, the structures for enabling belonging or membership will be focused upon next.

In Ward A there was the highly visible surgery specific post-surgical routines and a heterogeneity of patient and care staff experience and the different locations and opportunities for patient networking. All these structures were likely to promote access to a knowledge of what recovery in practice meant. Legitimate peripheral participation (Lave and Wenger 1991) by the newly admitted patients was possible. Socially situated learning involves an ongoing, changing, participative, negotiative process. In terms of 'cultural transparency' (Wenger, 1990), Ward A was more than a context with clearly visible ways of going about recovering from surgery. From the accounts there were clear evocations of membership. The participants seemed to be making clear their ownership of where they were in the process of recovery. This could be seen in the narrative concerned with what seemed a relatively confident renegotiation of what this entailed when convalescence continued at home. An example of this was Participant 4's (A) story of deciding to do her first laundry since her discharge. This gave a glimpse of the personal decision-making involved as well as the negotiative work done with her husband, in setting limits to her exertions. The high level of awareness of how the system of recuperation worked in the

ward, indeed that there was an identifiable system of participation suggests a good degree of coherence within the structures of participation .

Unlike Roth (1963), and his patient peer group, with a lengthy period for peripheral participation (Lave and Wenger, 1991), the length of stay of surgical patients in Ward A was relatively short, about ten to twelve days. However, it is possible that the close proximity to each other, of being all involved in the same highly specified system of remobilization facilitated a learning process for the patients. At one level the accounts are displays of a knowledge of the experiences of the others within the ward and at another, less direct level, they are displays of relations of 'knowing' between the experiences of these other patients and those experienced by the participant. Participant 7's (A) vignette of another patient's recovery was placed within a contextual script in which she and her husband, who had had a history of two hip replacements, jointly judged the success of the patient's surgery. In addition, it is argued that, because of the very specific routines of rehabilitation in Ward A, the different kinds of participation, were perhaps more discernible to the participants. This, it is suggested, would enable self-evaluation. The performances of others were a reminder of personal performances past and present and suggestive of those for the future.

### ***Section 2: Ward B***

The almost total absence of the participants' peer patients or the health care professionals generally or individually, from accounts from Ward B was a distinctive difference between the two ward groups. This lack meant that there was little glimpsed of what kind of socially situated activity took place in Ward B. If there was peer networking in Ward B, it was not referred to. The processes of recovery undergone by 'generations' of post-surgery patients in Ward B were not represented. Much of the reason for this may have been to do with the invisibility of the process of recuperation in peripheral vascular disease. Structures for participation such as the highly routinised remobilisation system in Ward A were not appropriate for patients recovering within a context shaped by the ongoing consequences of chronically damaged arteries. That there was a singular lack of narrative or accounting to do with membership may have been because there were no 'rules' to recovery. It has already been noted, from the interview with the Ward B charge nurse, that as far as the 'do's and don'ts' of convalescence were concerned, there was a



professional position of not providing specific instructions. Participant 1's (B) lengthy episodic narrative of her quest for rules seemed to corroborate this.

The researcher argues that the sorts of situated learning that happened in Ward B were less accessible through the accounts of the participants. Aside from the methodological limitations of interviewing, there may be several, possibly related, reasons for this. Firstly as already mentioned there was the relatively low visibility of recovery experience amongst the patients. There were less observable 'eras' (Zerubel 1979) in the recovery trajectory of Ward B patients. Recovery from arterial surgery is a much more sedentary experience. The only rehabilitative advice to patients presented in the accounts was 'Keep your leg up'. Rest as opposed to remobilisation was a major characteristic of recovery for Ward B participants.

There is nothing within the Ward B accounts to compare with the temporal emphasis identified in the Ward A accounts. By this is meant that in the latter accounts there seemed to be a marked communication of time within the narrative of day-to-day activities as well as through the generational perspective applied to the activities of other patients in the ward. Those structures for participation that were observed by the B participants may have been less easy to talk about. For example, the very visible experience of amputees in the ward may have been seen as either not relevant to the participant's own situation of arterial repair or the sight of recent limb loss or gangrenous toes, may have brought home to her a dangerous, hitherto unthinkable, future. There was then perhaps, a non-therapeutic visibility within the context that was Ward B. In addition the more visible and potentially positive remobilisation structures for amputees took place later when the patients were transferred to a long term rehabilitation hospital.

It has been argued from a sociocultural learning perspective, that a setting with a heterogeneity of experience was contextually supportive to participative learning. The possible difficulty for Ward B patients was too wide a variety of experience to observe and talk about. In addition, it was an experience which was not linked to an easily discernible scheduling of recovery activities. Patients having relatively minor varicose vein surgery, patients having emergency surgery for obstructed arteries, patients having emergency and elective amputations, patients having reconstructive arterial surgery, all shared recovery within Ward B. Each kind of surgical intervention necessarily entailed differences to the

sort of convalescence experienced. Heterogeneity was not so much 'generational' in the sense of most of the patients being at some point on the same recovery continuum as in Ward A, but of there being several different recovery continua with different beginnings and endings. Relations between people in this context were less likely to make clearer what the process of recovery involves. It is suggested that relating Lave's and Wenger's (1991) argument to the context of Ward B leads to the qualification that heterogeneity of experience is only supportive to participative learning in a situation of relative homogeneity of purpose. In other words, there is a shared sense of what has to be done and what has to be achieved. It is postulated that in Ward B such a context, did not exist where there may have been only one other patient who had undergone the same surgery in the ward at any one time.

Pursuing the notion of homogeneity of purpose there may be something further to explore in a comparison of context between the two wards. Ward B had no equivalent to a pre-admission clinic. With the clinic, the orthopaedic patients had access to a heterogeneity of professional experience, priorities, perspectives and communicative relations. This heterogeneity was at one in the pursuit of patient assessment and preparation for surgery and crucially, for the recovery period afterwards, both in hospital and at home. In addition, purpose was centred upon surgical events which had some predictability of outcome. For peripheral vascular patients however, to be about to undergo surgery may have been the confirmation of the chronicity of their condition and a very uncertain future ahead (Ronayne 1989). For these patients there was not only the risks of surgery to contend with, but, most importantly, there was an ongoing unpredictable illness likely to overshadow any recovery experience. To recover from peripheral vascular surgery it would seem that any participative structures must have some focus upon the participant's future with a chronic illness. From the Ward B accounts there seemed to be little or no evidence of such structures. That there was an absence of portrayals of membership within the Ward B participant group is significant. Perhaps the reality of Ward B was a lack of 'cultural transparency' (Wenger 1990). By this is meant that the low visibility of **recovery** processes, a possibly distressing, non-therapeutic visibility, and the lack of professionally imposed 'rules' all contributed to the lack of structures for ongoing, changing participative practice and for the development of membership. In Ward

B, it is mooted that a 'black box' (Wenger 1990) situation may have existed. In such a situation there is a lack of access to knowledge for an understanding through practice in what one has to do to get through the recovery period. In the case of Ward B participants, it is suggested, that the participative structures were not there in the ward to enable them to engage fully in socially situated learning activity. That there were marked differences between the two sets of ward accounts which may suggest the presence or absence of participative structures does not, of course, mean that there were no participative structures in Ward B. Rather, it could mean that the Ward B version of participative structures were less accessible by way of the interview.

### **Part 3: Forms of participation-recovery work**

So far the search for participative structures has been, in the main, within the institutional characteristics of Wards A and B. According to sociocultural learning theory, communities of practice are not 'designed' but are 'naturally occurring social phenomena', which constitute an ever-changing, adaptive response to the demands of living and acting in the world (Wenger 1990, p147; Lave and Wenger 1991). What the 'adaptive response' was within the two wards will be explored in terms of practice.

Comparing the accounts from the two wards appears to corroborate Wenger's (1990) insight that within communities of practice there are continua of participative and non-participative practice dependent upon the sets of relations and contextual structures in situ. To get closer to describing what may have been happening in wards A and B in relation to these continua of activity, what forms of recovery practice were represented within the accounts will be reviewed. Strauss et al's (1985) concept of patient 'trajectories' as it relates to the kinds of work undertaken by patients is helpful in elucidating what these recovery practices may have been in the two surgical wards.

#### ***Section 1: Recovery work in Ward A***

The idea of 'patient worker' seems to most easily fit with the Ward A accounts. The orthopaedic patients were very visibly put to work towards their recovery. There was a very visible recovery continuum. Patients, from their descriptions, were caught up in a rolling programme of practice for recovery. 'First time' practice activities were most often remembered and with the temporal details of when on the participant's trajectory they took

place. The participative relations of this trajectory were recognised by all, staff and patients as working relationships. Throughout the whole process of recovery in hospital the highly visible remobilisation, recovery work of patients was 'legitimate' or professionally and socially approved activity. Legitimated participation in their recovery was referred to by all the Ward A participants presumably because of its legitimacy and therefore as 'evidence' of membership of a socially approved community of practice.

A distinctive feature of the community of practice that was glimpsed through the Ward A accounts was the infrequency of direct referrals to the professional staff. Patient-staff relations that were mentioned do provide an insight into particular participative experiences the participants had with the health professionals. Participant 16 (A) told the story of her negotiation for discharge with her physiotherapist, concerning her performance on the knee mobiliser. Participant 11 (A), of a supportive yet 'business'-like relationship with a staff nurse as she emerged from the first few days of total dependency. Overall however, there was no specific 'special mention' of particular care staff which would perhaps have made clearer what kind of working relationships were held with different sorts of care staff. Like Hill's (1978) subjects, Ward A participants did have individual sessions with therapists, with physiotherapists in particular, but dealings with them were portrayed as part of a whole hospital experience of the recovery process. This indirect and in the main, positive reference to professional staff within the everyday context of hospital routines and activities, corroborates to some extent Albrecht's and Adelman's (1987) case that a variety of weak relationships which sometimes involve quite routinised interaction were more likely to be experienced as socially supportive and therapeutic than some closer relationships. Wilson-Barnett (1988a) had noted that the caring contribution of nurses may not be mentioned by patients because they were embedded within the everyday complexity of relations that make up the overall care context. The 'ideology of intimacy' (Adelman et al. 1987) should perhaps be laid aside in the exploration of relations of care between patients and health professionals. Strauss et al (1985) have described some of the 'work' that patients do for themselves or for other patients, for example, complementing, supplementing or rectifying the mistakes of professionals. A 'work' perspective points to a complexity of care practice from all in the recovery setting.

Another glimpse of the form of recovery work that went on in Ward A may lie in the portrayal of visible work undertaken with others and in a context of a shared travail. From a socio-cultural perspective an essential part of such sharedness in highly visible recovery work would be that of an informal observer and assessor of other patients' efforts. Marshall (1972) noted the value to learners of being watched by others with a range of experience in the skill to be achieved. Nelson's (1990) study of a spinal rehabilitation ward portrayed a complexity of interactive feedback and behavioural conditioning experienced by new patients from the 'older' patients in the unit. Although the complexity of relations of recovery practice, the different forms of participation with different members of the community, the existence of different or parallel communities of practice and changing degrees of participation within the hospital context, may be less easy to discern without direct participant observation, nevertheless a strong evocation of a community of practice was identified in the Ward A accounts. Communities of practice were accessible to some extent to the researcher through the collection of accounts because of the function of accounts as motivated representations (Silverman 1993) of membership or non-membership.

One sort of communal evocation appeared to encompass the Ward A experience in general. It was an experience portrayed as working in response to institutional structures and goals concerned with efficient processes of admission, surgical care and successful recovery. Some of the community evocation appeared to be on this all inclusive basis, with health professionals and peer patients united in a common goal of achieving a speedy recovery. Another kind of community was evoked through omission which seemed to identify a separate patient community of practice acting in response to another practice group which was made up of all the health workers. A 'them and us' sort of relationship was suggested, in which participation took the form of necessary obedience or compliance in relations with professionals, of 'doing as you are told'. This participant awareness of the patients' form of participation may have been something to do with the distinctness of the multi-disciplinary dimension of the care work in Ward A, and to the coherence of the associated activities, for example the weekend exercises set by the physiotherapists. A coherence represented in narratives about a scheduled progress moved along by interlocking professional interventions.



So far the forms of participation postulated have, in the main, been those to do with the visible work in Ward A (Strauss et al 1985). Another kind of activity which could be identified as recovery practice was more invisible. An informal peer feedback on performance has already been mooted. From the narrative focused upon the others within their community of practice, there were glimpses of participation which was strongly evaluative in character. Another glimpse of the evaluative nature of peer relations and of patient work, was the apparent close monitoring of peers, found in the narrative detailing the progress of other patients. This kind of informal patient work was identified by Strauss et al (1985) amongst renal dialysis patients. Whether the monitoring was to do with 'keeping an eye on' another patient in the absence of the staff, or information-gathering through direct observation, it was participative work. Whether the monitoring done by Ward A participants was one or both of these things, it was more evidence of the complexity of activity within the patient community. The social context in which the recovering process was situated cannot be separated out as the environment in which learning took place because the context itself was portrayed in the accounts as an integral part of the process. In other words, it is posited that other patients' work was a significant feature in the recovery of the individual participant.

Further peer evaluative work seemed to be rooted in peer networking and this included discovering about the 'failure' to recover in the sense of a slower or unsuccessful recovery by another patient. As Wenger (1990) pointed out, communities of practice contain those who do not achieve what was to be learned. From the Ward A accounts it is suggested there was other information exchange concerned with past and present failure to recover and that this was part and parcel of the situated learning experience of this orthopaedic ward. Comments by the medical staff at the pre-admission clinic as to the risks attached in undergoing specific orthopaedic surgery were reinforced when other patients shared their past or present predicaments with the new patient.

In addition to narrative which alluded to participant activity, there were intimations of other kinds of patient work. Apart from the insights into the work patients do in hospital, the accounts also contained participants' portrayals of their recovery work in the context of their own homes. The glimpses of patient 'homework' were to do with the participants' preparations for admission to hospital or recovering post-discharge. For



some of the participants the homework was the 'tholing'<sup>1</sup> work when there had been a lengthy wait for admission while their condition continued to deteriorate (Participants 11 and 8 (see pp108 and 116 respectively)). Some of the participants' theories (for example Participant 4's 'right attitude') shed light upon other forms of patient work that took place at home, for example, getting through a difficult transition period or the work of dealing with the isolation of lengthy, at times, debilitating recuperation experiences.

## ***Section 2: Recovery work and the Ward B participants***

Glimpses of a community of practice in the Ward A accounts has been linked to evocations of a 'shared travail' amongst the patients. The relative absence from the Ward B participants' accounts of a recovery shared, would seem at first to make it impossible to discern what kinds of participative recovery practice may have existed in Ward B. It has already been suggested that Ward A's shared travail experiences were made more accessible because these experiences were in response to a professionally orchestrated, very visible, scheduled rehabilitation. Talking about these recovery experiences then, had the legitimacy associated with the doings of health professionals. With apparently little in the way of institutional structures to respond to in participative ways, there was little of the 'visible' forms of participation in the Ward B accounts. What was there however, was a good deal of patient activity represented in narrative to do with the more invisible emotional work carried out by the study participants. Like the Ward A participants, this 'compassionate' (Strauss et al 1986) narrative was in the main focused on periods of experience outwith the time spent in hospital. What was different from the Ward B accounts, seemed to be the breadth and depth of the emotional work evoked. Conveyed through what was said and what was left unsaid, the Ward B accounts were illuminating concerning the frightening implications of peripheral vascular disease and of the work undertaken by patients to deal with these implications. Preoperatively, the accounts from the participants with peripheral vascular disease evoked something of the emotional work

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<sup>1</sup>from thole, a Scots word with a wealth of related meanings which seems to encompass the breadth of experience evoked by the participants. - To suffer, have to bear (pain, grief etc); to be subjected to; to be afflicted with. To endure with patience or fortitude, put up with, tolerate. Allow, permit, suffer. (adapted from Robinson, M. (ed) (1987) *The Concise Scots Dictionary*. p715.

associated with the news that surgery was needed. The degree of distress and the fear for the future was conveyed often by omission. There were various responses to a perception that a momentous life event was about to happen. Examples of such responses included the reassessment of the suitability of one's home; undertaking a life review (Participant 13); dealing with the knowledge of the risk of sudden death or preparing oneself for the bad news of failed surgery (Participant 3's 'bargaining talk'). Participant 14's (B) justification for her delaying tactics to requests from the hospital to come in for surgery – 'It's not a tooth I'm getting out!' graphically alludes to something of the 'homework' done before committing to the proposed surgery.

The patient work identified within the Ward B accounts post-surgery was to do with the unpredictability and length of recovery from peripheral vascular surgery. Stories of distress concerning the development of complications in hospital and at home and the evocations of fear and resignation were characteristic of these accounts. Both 'unpredictability' and 'lengthy' function as descriptions of particular experiences of time. It is suggested here that it was the presence of the former which made for the greatest difference between the two sets of recovery accounts. To reiterate, the evocation of a shared travail from the Ward A accounts was made through a temporally dominated narrative to do with perceived routinised experiences. Forms of participative learning were located (by the participants), within a temporal structuring of experience. Time as a social construct (Adam, 1990) seemed to function in two ways. In one way as a means to convey individual and shared progression or relative 'failure' to progress. It also appeared to function as part of the 'visibility' of patient recovery in Ward A. Apart from the cultural acceptability of a temporally dominated narrative, this temporal 'visibility' in 'reality' brought a degree of predictability to the Ward A participant recovery experiences. The 'rules' or 'do's and don'ts' of activity were it could be argued, more visible because they were closely linked to a temporal framework of participation. From the accounts, it would seem that for the individual patient, ways of participating, were initiated, were changed, were abandoned, in response to a rehabilitative context determined primarily by her post-operative date.

Returning to the Ward B accounts, these were narratives dealing with a different relationship with time. Time that was especially significant within these accounts, was

event driven. The participants in the community of practice that was Ward B, whether patient or carer, seemed focused upon responding to what was the ultimately unpredictable process of PVD rehabilitation. A process which is filled with events related particularly to wound healing. The form of patient participation seemed to be a relatively solitary, individual experience and was characterized by 'tholing', a gritty, putting up with response to an adverse context. In the case of Ward B, this tholing by the patients was to do with the lengthy healing and proneness to events related to the complications of PVD. Such an activity, is less visible and less active in a physical sense. How new patients participated in a legitimately peripheral way (Lave and Wenger, 1991) and learned what was involved in recovering, was less accessible through the accounts because of the relative invisibility of the activity to be learned.

The accounts betray very little of the kind of situated learning that may have been going on in Ward B. This it is suggested, does not mean that the Ward B participants were more likely to be at the non-participative end of a practice continuum (Wenger 1990). It is mooted that patients' active participation in the practice community that was Ward B, was of the silent, uncomplaining, cooperative kind that would have been needed to assist in the care procedures of the professional staff. The experience of recovery was focused within the context of the post-discharge home setting. Unlike the Ward A accounts which seemed to present an adherence to rules learnt in the ward, the Ward B stories centred upon the participant and her friends' and family's attempts to manage the unpredictable events of post-operative PVD surgery as well as reviewing the hospital encounters with staff for some indication of rules concerning levels of mobility. That some sort of learning did take place seemed evident from the accounts. A particular evocation from the home based accounts was of having gone through a good deal. Resignation and patience and espousing limited goals that were more achievable, were perhaps the products of a learning experience that was Ward B, peripheral vascular surgery and the long, unpredictable recovery at home.

#### **Part 4: 'What helped', addressing the teaching-learning process of recovery**

Hill's (1978) perspective as to the dual processes involved in rehabilitation will be utilised to explore the issue of what may have helped recovery. To reiterate this

perspective, rehabilitation is an activity consisting of two parts. One which is concerned with the specific task of establishing capacity and the other is a teaching-learning process addressing its utilization. From a sociocultural learning perspective, such processes are to do with a complexity of relations within and across social contexts (Lave 1993).

When both sets of participants were asked what it was that helped them to recover, Ward A patients' accounts evoked a highly structured, shared passage with other patients in the ward. Some went as far as to theorise as to the benefits of such a communal experience. Ward B patients, on the other hand, seemed to have difficulty answering questions as to what was therapeutic for their recovery. This may have been due to the generally longer period for recovering from peripheral vascular surgery which may have meant that the hospital experience was not so filled with 'eras' (Zerubavel, 1979) which could be focused upon as watersheds of progression. The already stated proposition that progression for the orthopaedic patients was represented as to do with post-operative days whilst PVD patients necessarily had to work with an 'event' driven experience, (Roth, 1963), may have been pertinent. It seems likely that if the PVD patients learned how little active control they could exert upon their illness and that the surgical event served to confirm this, (Ronayne, 1989), any therapeutic functions carried out by the surgical care staff or others may have been less visible to them because of this. What the PVD participants did dwell upon, was the kind of helping that took place when they had returned home.

The experience of a shared travail was constructed by Ward A patients as a positive picture of successful recovering. How this sharing may have helped, has in the main, been discussed in relation to structures and forms of participation in learning. Being engaged in the situated activity provided access to a body of knowledge about recovery. Evidence from the accounts of this activity was of two sorts. Firstly, 'sharing narrative' and goal-setting representations of responsibility based upon peer comparison glimpsed at a 'generational' body of knowledge in which 'recovery' was part of the foreseeable and relatively positive future. The second sort of evidence of such situated activity was found in the evaluative content of the narrative concerned with the individual's recovery as a specific process. This evaluative activity related to a body of knowledge of 'doing'

recovery. In other words, recovery knowledge was accessed through practice (Engestrom in Lave 1993 ).

That a practice experience generated a knowledge of process was glimpsed in what up to now the researcher has described as the theorising activity of the participants. It would be more accurate to describe this as practical as opposed to theoretical reasoning (Carr, 1981) given its prescriptive nature. By that is meant that in effect participants sought to set out what the rules of the doing or recovering were from their own experience. This theorising, it is suggested, was born of knowledge only gained through a complexity of participative practice in recovering within the ward and at home. It is suggested that the participants' theorising gives an insight as to this complexity of practice in providing glimmers of the less visible or obvious activities and contexts of recovering. Facets of recovery activities and the contexts of recovery were found in narrative concerned with supporting ideas of 'atmosphere' and 'conveyor belt' experiences or with making comparisons of personal recuperation vis-a-vis other patients within a time scheduled ward context.

It is the nature of stories to present context and sets of relations and the activities that are generated. The stories narrated by the participants, in response to questions about what helped, were no exception. What appears generally to distinguish the two sets of accounts was the kinds of participative practice continua (Wenger, 1990) that were evoked. It has already been suggested that representations of responsibility detailed from Ward A participants were about rule-following, that is complying with professionally prescribed routines and rules of activity while those from Ward B ( who referred to their hospital experience in any detail) seemed to be about rule-hunting. This rule-hunting consisted of seeking out professional advice or information as to what might be the boundaries for safe remobilisation. From the Ward A stories there were many glimpses of peer interaction, the sharing of past and present experiences so that it could be assumed that there was another participative continuum characterising the situated activity of the ward. The new orthopaedic patient then, was likely to have at least two parallel and interactive participative continuums within her practice community towards which she could relate to in a legitimately peripheral way (Lave and Wenger 1991). Because of the complexity of practice experience generated from a range of 'doing' from two practice



continua and the relative homogeneity of purpose, there was likely to be frequent access to the practical, 'recovering' knowledge involved in hip and knee surgical recovery.

From Ward B there was a relative absence of reference to 'others'. This does not mean of course, that there was no peer interaction. It has already been suggested that the Ward B participants would have less motivation for including the experiences of others due to differences in context (ie lack of visible progress, the level of uncertainty as to prognosis etc.). However, the Ward B accounts did have more narrative to do with the participants' interactions with the care staff. These narratives were linked to rule-hunting activities and were, it is suggested, representations of one sort of participative activity by patients in Ward B.

By examining the narrative content to do with rule-hunting in Ward B, something of 'what could have helped' was glimpsed. Participants told stories about looking for information or advice to do with what were the boundaries for safe practice. Their pursuit and questioning of the health professionals was for knowledge of 'how'. Examples of this kind of knowledge were knowing what to do if a wound looks inflamed or feels sore or whether exercise that took one through a pain barrier was therapeutic or damaging. The professionals were portrayed as either providing theoretical 'about' sort of knowledge such as the percentage of extra blood flow to the brain or if pressed they would exhort the participants to use their commonsense. This advice concerning commonsense was interesting because it was an inference to the practical or experiential. A trial and error process of learning how was being expected of patients. The difficulty with this is that commonsense is based upon practical logic which is dependent on a knowledge of rules of practice (Carr 1981). From a sociocultural learning perspective gaining a knowledge of how to recover happens through relations and communities of practice. As there seems to be a dearth of knowledge of recovering in society, not to mention amongst health professionals (Baker, 1989), the new PVD patient was not likely to come pre-equipped with the rules of recovering practice. It has been already noted, that there was an awareness by the care staff in Ward B, of the patients' demands for 'black and white' advice concerning remobilisation. Recorded too had been the staff's refusal to meet this demand. The rationale for this refusal given by the ward charge nurse and echoed in the narrative of the participants was couched in terms of the uncertainty of scientific



knowledge. It seemed as if the approach adopted by the Ward B staff was only to view the issue of rehabilitation from the perspective of what was known theoretically about the healing process of the vascular and venous systems of the body. The inadequacy or unrelatedness of this 'about' knowledge to the everyday recuperative knowledge needed by the post-surgical peripheral vascular patient has been highlighted in this study.

The kind of 'how' or applied knowledge mentioned by both patient groups was to do with being able to gauge from appearances, functionings, ease of functioning, whether the participant was ready for a new stage or 'era' (Zerabavel, 1979) in their recovery. The Ward A group which seemed, in comparison to Ward B, to have been equipped with a good number of practical rules or 'rational procedures' (Carr, 1981) as to how to conduct one's recovery in hospital and at home, communicated only a few queries as to how to conduct their particular process of recovery. These were about issues of process such as when to give up both walking sticks, or whether pillow positioning could be abandoned. In the main though there was much within the post-hospital narratives from the Ward A participants to indicate that 'how' knowledge had been learnt and had been applied to the home recovery process. It is suggested that there were two ways in which this was conveyed. From the initial analysis, the narrative was identified as function dominated. There was much about achievement linked to process. This linkage was conveyed in stories of the passing of milestones such as being able to hang out one's own washing or fill the washing machine, or getting out for a trip in a friend's car. This narrative was sprinkled with references to rules of mobility learnt in hospital.

That Ward A participants had learnt something concerning the 'doing' experience of recovering at home seemed also to be conveyed in the self-confidence evoked concerning the changes they undertook. This evocation seemed to be communicated in the matter-of-factness in the telling of their practice experience. What could be termed 'informed doing' practice such as casting aside a walking stick, picking up objects from the floor, were described. What tended to be left unsaid about this activity, was the decision-making process that would be made for such practice changes. Only in Participant 4's (A) vignette of her first days at home and working out what she should do next when she had to perform some movement or other, was there narrative to do with a decision-making activity. 'Informed doing' and decision-making as to changes in practice requires an

amalgam of theoretical, applied and practical knowledge which, according to Lave and Wenger (1991), can only be learnt if the learner/patient can participate legitimately and peripherally in the community of practice.

Within the participants' accounts the rule-following and the rule-hunting represented seemed to give an insight as to the kind of knowledge utilised or desired respectively. This knowledge was of the applied 'how to' sort which relates directly to the actual practice experience or work of recovering. It is suggested that for the utilization of capacity (Hill 1978), there has to be a context in which there is a complexity of social relations of practising recovering because this facilitates access to a minutiae of knowledge to do with the physical, social and emotional threads of the process of recovery which the participant contributes to as well as taking from. This leads to a greater focus upon the degree of cultural transparency (Wenger 1990) (see page 25 Chapter 2), that may have existed in Wards A and B. 'Transparency' relates to the sociopolitical organisation of practice which enables the formation of identities of membership necessary for learning. In the case of Ward A, the routine of remobilisation could be described as facilitating an 'anchoring of participation qualities' for the participants (Lave and Wenger 1991) in the sense of being a focus for shared understandings and meanings of what was to be done. From the Ward B accounts in which participation was mostly represented as 'tholing', the knowledge 'window' (Lave and Wenger 1991, p103) may have been a less transparent. However, it may have been no less accessible to the participants by way of participative and non-participative relations with staff and other patients which were distinct to Ward B. How helpful or therapeutic such 'windows' were, is of course a separate issue from whether learning took place. In this study, there was little from the Ward B participants concerning what helped. In the case of the participants who had PVD surgical intervention, recovery was a protracted incomplete experience and, as a consequence, help in various forms was needed. Perhaps then, in the case of Ward B, greater attention should have been paid to what knowledge would have been helpful and how it may have been made more 'visible' or accessible to patients. Given the event-driven nature of PVD, it may be that some focus upon the detail of such events could have teased out what was predictable or tangible. In that way the participation frameworks may have widened and become more complex in response.

## *Chapter 7*

# **Conclusions**

In this chapter the thesis is summarised and its contribution to knowledge is discussed including the possibilities of future research. Finally, the limitations of the study are revisited.

### **Part 1: Summary**

The purpose of this study was to explore female surgical patients' descriptions of what for them, constituted the experience of 'recovering' and to find out what helped or did not help with this experience. Patients' accounts of their experiences of recovery were obtained from two participant groups undergoing surgery in Ward A an orthopaedic ward and Ward B, a peripheral vascular unit, located in two separate hospitals within a NHS trust in Scotland. Taped, semi-structured interviews were carried out pre-operatively in hospital and post-operatively in the participants' own homes. Questions were devised with the aim of generating narrative. The resultant participant-interviewer 'conversations with a purpose' (Burgess 1984) were transcribed and examined for participant story-telling and episodic narrative. The task of narrative recognition was achieved by examining the content and structure of the transcriptions. This examination consisted in exploring the content for themes and identifying narrative features such as 'well-formedness' (Askham 1982) and diachronicity. Using Bruner's (1991, p4) description of narrative as 'interpretative and in need of interpretation' the accounts were analysed individually, as well as within and across the two participant groups.

The comparative analysis between the two groups of participants revealed the presence and absence of portrayals of the recovery experience as a 'shared travail' in Wards A and B respectively. Recovering as communal, and sharedness as therapeutic were themes found within the narratives of the orthopaedic participants. Reflective and sense-making activity by the Ward B participants produced no such portrayals of their hospital experience. This study adds to the limited work that has been carried out concerned with the surgical patient's experience of recovery. The difference between the

two sets of accounts in terms of ‘communal narrative’ led to the adoption of the Lave and Wenger (1991) theory of sociocultural learning. In the further analysis that followed, a greater complexity to the task of understanding and explaining patients’ recovery experiences was identified. Continuing the task of summarising, the following sections will address the detail of the contribution to knowledge of this thesis and the pointers for future work.

## **Part 2: Contribution to knowledge**

### ***Knowledge of recovery shared by the patient group***

That recovering was a learning process, located in a communal, shared place was identified from the Ward A narratives which conveyed a sense of what it was like to recover in the ward and by narratives when participants theorised as to what it was within the ward that aided recovery. Both sorts of narrative from the Ward A participants framed the experiences and theories around the professionally prescribed, day-by-day remobilisation routines. The framing of experience around these physical experiential frameworks suggested a coherence to the structures of participation in recovering. Within the accounts there was a very specific group produced knowledge of recovery which related to the time sequenced routine of progressive ambulatory activities. Patients had access to a knowledge of how a recovery trajectory was configured. In Wenger’s terms, Ward A had a cultural transparency. Future work could be undertaken to look at the sorts of shared knowledge held by different patient groups. From this study it was noted that the knowledge shared by Ward A participants, was often diachronically structured and presented with some fluency, whereas in the case of the participants from Ward B with a more event-driven convalescence, shared knowledge was less positively portrayed and less accessible, at least within an interview setting. It may be that the exploration of narrative which points towards there being a shared knowledge within a group of patients would provide professionals with insights as to the complexity of ‘doing’ recovery knowledge.

### ***The nature of a heterogeneity of experience: positive and negative portrayals***

The pertinence of a heterogeneity of experience for recovery learning was noted in this study in relation to the ‘generations’ of patients who were undergoing similar surgeries. Further work could be directed at looking at the nature of this heterogeneity as

it relates to positive and negative portrayals of sharedness. This research pointed to a relationship between negative portrayals of recovering and a particular heterogeneity of experience. This heterogeneity of experience was related to sharing recovery from surgery with others who were at different points upon a continuum of chronicity. Not only did this mean that different kinds of surgery were carried out but also that there was likely to be an unpredictability to each patient's recovery. In contrast, positive portrayals related to a form of heterogeneity of experience concerned relations with others who were undergoing very similar surgery in the narrow time frame of the convalescence in hospital. In other words 'acceptable' heterogeneity was about differences of days or weeks in the timing of very similarly structured and relatively predictable rehabilitation. In other words, heterogeneity that was 'acceptable' to the participants was that which involved conditions of recovering with which they could identify. Positive portrayals were linked to contexts of relations with which the participants could claim membership. To clarify, the Ward A patient experience was more homogenous than that of Ward B. However, the experiential heterogeneity that was presented was a context in which there was access to 'generations' of patients at different stages of recovery from similar sorts of surgery. Apart from the similarity of surgery and a narrow convalescent time frame, claims of belonging or sharing were placed by the participants in a social context of a visibly structured routinised rehabilitation. That this structured experience was presented by the participants in terms that suggested that a homogeneity of purpose existed adds further complexity to the study of recovery. Perhaps a fruitful line of enquiry for future rehabilitation research would be to address the relative heterogeneity and homogeneity of patients' experiences.

### *Accounts of less 'successful' recoveries*

Identified in the data gathered from those participants who provided 'deviant' accounts and/or who had had difficult, complicated recovery experiences were contexts of relations of non-participation in learning such as not participating in the routines of remobilisation or being unable to obtain professional advice which addressed an applied knowledge area such as safe levels of physical activity. Addressing the 'deviant' or the 'exceptions' (Hammersley and Atkinson 1995) led to the generation of ideas concerning the hidden emotional work of patients and to the contrast between event and temporal-

driven recoveries. Further research which attends to these exceptions is likely to extend what is known about the processes of recovery.

### ***Recovery learning and the patient work perspective***

This study could be extended to look more closely at the experience of the patients who have a more event-driven 'shared' convalescence. Rather than seeking glimpses of sharedness through descriptions of remobilisation schedules, research could utilise Strauss et al's (1985), concept of 'patient work'.

The adoption of this work perspective in the interpretation of the 'responsibility' and 'tholing' narratives of the Ward B participants was another contribution to knowledge. The utilisation of Strauss et al's perspective (see Chapters 2, 5 and 6) served to elucidate that what was learnt and why was rooted in the social and cultural context of everyday living in the world. The researcher argues that the application of a theory of 'patient work' to assist in the sociocultural learning interpretation of the participants' accounts of recovery was a fruitful and novel approach. The 'invisible' as well as the 'visible' learning experiences were elucidated in this way.

### ***Contextual relations and recovery learning***

The contribution of this research in highlighting the shared quality of recovery has been noted. Further, the interpretation of this sharedness using sociocultural learning theory is a contribution to the body of knowledge concerned with patient education in that it provides a more fruitful approach to understanding the processes involved because the learning rather than 'patient teaching' is addressed. The application of Lave and Wenger's theory necessitates an exploration of the relations of context of learning. This is in contrast to the current individualised, professional-patient construction of patient education. The learning theory in this study challenges the underlying assumption of such a construction that the goal of 'patient teaching' should be only in terms of the transmission of existing knowledge (Engestrom 1987, in Lave 1993). The participants' stories gave insight into how new knowledge, the experience of learning to recover in practice is acquired through a complexity of social relations. Studying the nature of the recovery experience needs to be about addressing the nature of the social and cultural relations that the patient experiences throughout his/her 'travail'. The identification of positive portrayals of the routines by patients in this study provided insights into the relational complexity of recovery. The Ward A participants' experiences in hospital were



all essentially communal, even the apparently solitary 'first walk' because everyone, patients and staff participated within a highly visible routine of practising recovery. It is suggested that future research would include looking specifically at care routines and their place in the development of the knowledge of 'doing' recovery.

The Ward A routine that was evoked was very 'visible' in the sense of making clear what were the rules, expectations and responsibilities of the patients. Narrative concerned with the routine, for example, the 'first' stories, located the practice of patients as participants in the remobilisation of others. No routine was glimpsed within the Ward B accounts. The contrast between the two sets of accounts, concerning relations of context, in particular, 'rule-following' (Ward A) and 'rule-hunting' (Ward B) was linked to the presence and absence of 'routine' respectively. The identification of positive portrayals of the routines by patients in this study, challenges contemporary nursing perspectives which focus upon individualised, one-to-one care and which do not attend to the communal patient experience.

According to Lave and Wenger, identity development is crucial to the careers of 'newcomers'. A prerequisite for learning is an identity based upon membership of a community of practice. In this study there were presentations of self-responsibility which were common to all the accounts from both sets of participants whether it was to do with looking after the surgical work or through owning 'fault' for one's condition through smoking. These presentations were interpreted as concerned with membership and so with the sorts of relations that may have existed within each ward. From what was gleaned from the accounts of both sets of participants, the researcher would corroborate the view of Lave and Wenger (1991), that routines functioned to 'anchor the participation qualities of a community of practice'.

### ***The role of nurses and other health professionals and locating the 'doing' of recovery***

In this study it has been suggested that the place of nurses and other health professionals in the learning experience of the patients, is to be found in the multiple levels of participation in the practice of recovering identified in the patients' narratives. From the Ward A narratives, nurses appeared to orchestrate the highly visible routines. This orchestration included the 'first' events, which in the telling, suggested that nurses 'supportively abandoned' their charges. The Ward B narratives hinted at a reactive

relationship between nurses and their patients. This relationship seemed less than satisfactory in that the form the reaction took failed to deliver help by way of rules of practice or 'doing' recovery.

Further research as to when and where recovery learning may take place might focus closely upon how the relations of doing relate to the 'developmental cycle' of the particular surgical recovery. For example, research could be directed to points in time when different 'generations' of patients come together such as the days when new patients come to the ward or when they 'witness' each others' successful or not so successful achievement of particular 'benchmarks' of recovery.

Greater understanding of how the organisational ideology or reification system is presented within a clinical area, may identify more clearly the role of the nurse. In this study, nurses were identified as the 'translators' and 'transmitters' of more or less adequate reification systems. To elaborate, through the Ward A accounts there was a clarity and homogeneity of purpose promulgated through the temporally dominated scheduling of activities of recovery practice. Nurses were placed in this scheduling context as the people who initiated it and kept the momentum of progressive ambulation going. In the more event driven context of Ward B, the 'rule-hunting' patients were enjoined by nurses to use their 'commonsense' on the basis that if they could do a particular activity, then they should continue doing it. However, it has been pointed out in this study that the details of events need to be in some way, made more tangible so as to be a focus for the development of participative structures to provide a coherent accessible body of knowledge of the 'how' of recovering. Future nursing research could address this issue.

The final note concerning the contribution of this study to knowledge relates to the initial listenings and readings of the interview transcripts. What emerged from these activities was the presence not only of the health care staff, but of the other patients within the participant's ward. A communal perspective on the patient's experience provides a much wider and more complex picture of the learning process involved in recovering experiences. It is a perspective which places most recovery learning outwith any patient education interventions that may be given by the professionals.

### **Part 3: Limitations and strengths**

Aside from the difficulties associated with the use of interviews (explained fully in Chapter 3), this study was limited with respect to the number of times the participants were interviewed. A second post surgical interview to each of the study participants may have provided further insights into the nature of the process of surgical recovery as they represented it. Although additional ethical approval had been sought and given for a further round of interviews, time constraints upon the researcher prevented this.

The strength of this study is in there being two sets of patients' accounts from two surgical wards in two different hospitals. The development of new ideas and the adoption of specific theoretical frameworks were in no small way triggered by the discovery of similarities and differences between the two ward groups. A synergistic interaction in which a pattern or theme from one group informed what was learnt of the other and also contributed to what was said about the other. The value of this interaction is evidenced in such novel concepts as 'rule-following', 'rule-hunting' and 'shared travail'.

The researcher would like to suggest that a further strength of this study was in the adoption of Lave and Wenger's theory of socio-cultural learning hitherto unused in the study of recovery. The use of this theory provided a novel analytical framework to looking at recovery and facilitated the development of a more complex representation of this little researched area of the patient's experience (Olszewski and Jones 1998).

### **Part 4: Contribution to professional perspectives**

It is tentatively suggested that this study could contribute to professional knowledge in the sense that it looks in a new way at the patient's experience of recovery. Rather than taking an individualistic perspective, the rehabilitative experience is viewed as a communal and shared activity. The novel use in this work of Lave and Wenger's socio-cultural learning theory to interpret this recovery activity can, as pointed out in this study, give greater complexity to what is known about it. Addressing the recovery experience of the patient from a learning perspective which defines that learning as 'an engagement in changing processes of human activity' (Lave 1993,12), focuses upon the patient's knowledge **of** recovery. This 'knowledge', unlike the professionally focused knowledge **for** recovery, is always changing and is difficult to encapsulate. Identified in these accounts this knowledge **of** recovery was centred in the social and cultural context of recovering that the participants' were a part of. The place of other patients, of nurses and

other health care workers in this recovery context, was located in the multiple levels of participation that made up the patients' practice of recovering. Thus the methodological approach and findings of this thesis present a novel and cogent contribution to professional perspectives concerning patient recovery and patient education.

## *Appendix I*

# **Aide-memoire of questions for first and second interviews**

### **First Interview**

*Researcher introduces herself and explains/describes the research.*

“My research is about looking at what women have to say about their experience of recovery or rehabilitation from surgery.”

“The research plan involves talking with you on two occasions.”

*The researcher outlines the nature of the talks.*

“The first one is part of this interview. I have some questions to ask you about your own circumstances and your own thoughts about getting over the surgery.

The second session is a longer talk in which I will have some questions to ask you but a lot of the time I would like you to talk about your own experience.”

*Researcher invites the patient to ask questions and this is followed by decision-making concerning consent.*

### ***Social context and individual profile***

*Questions:*

What were your thoughts when you knew you were coming in for surgery?

What arrangements did you need to make before coming in to hospital?

Have you had surgery before?

***Thoughts about the recovery process***

*Questions:*

What do you think is involved in getting over your operation whilst in hospital? at home?

How long do you think it will take to get back to health?

***Thoughts about recovery goals***

*Question:*

What do you think for you, would be a sign of getting better? - (link to later session)

**Second Interview**

“My agenda is about

-your definition of recovery/rehabilitation

-your experience as you see it of getting better after your surgery

-what did/did not contribute/help to you recover

-I will be asking you about various specific things but do not let me stop you from telling your story, about your experience. I may not ask many questions because you give me the answers in your conversation to me.

If something does not make sense in what I say please say so.”

**(TAPE ON)**

***Experiences / stories of progress***

*Questions:*

Well how did it go? (narrative/story generation)

Tell me about a time while you were in hospital, which made you feel that you were getting better.



Describe to me a particular experience you had that for you, meant that your health was returning to you.

***Context which contributed/did not contribute/could contribute to recovery***

***Questions:***

How was your recovery/rehabilitation talked about while you were in hospital? By whom?

How did you find the change from hospital to home?

How did what was said and/or done in hospital help you to manage yourself and your circumstances when you went home?

Was there anything that was not said or not done in your opinion?

***Generating specific examples re defining recovery and personal recovery goals; place on the road to recovery; prospects for health.***

***Questions:***

You said before your operation that ((refer to what participant said about goals in first interview, (p2 of this appendix) )) would be a sign of getting better, what do you think now? (link to first interview)

How are you at getting about now?

What can you do?

Is that what you expected?

***Evaluative narrative generator***

***Question:***

If a good friend of yours was now going into the same ward for the same operation, what do you think she needs to know to get through all that is involved?

*Appendix II*

**Letter to ward managers**



DEPARTMENT of NURSING STUDIES

The University of Edinburgh  
12 Buccleuch Place  
Edinburgh EH8 9LN

Fax 0131 650 3891  
Telex 727442 (UNIVED G)  
Telephone 0131 650 3889

Dear Sir,

*Postgraduate Research Study*  
**RECOVERY FROM SURGICAL INTERVENTION: PATIENTS' ACCOUNTS**

I am a postgraduate student undertaking a Ph.D. research degree at the Department of Nursing Studies, University of Edinburgh. I have approached ---- the Director of Nursing and quality concerning clinical access for my research project. He has intimated to me that your unit can be involved in the project.

The research focus is upon female patients' experiences of recovery from surgery. Patients would be interviewed on two occasions the first being hospital based and prior to surgery. I appreciate the need for flexibility on my part in gaining time and space with patients and I am mindful too of the importance of ensuring that the requirements of the research do not impinge greatly upon you and your staff's time.

I would like very much to meet with you so as to elaborate upon the research plan.

Yours sincerely

Fiona Mulgrew

*Appendix III*

**Introductory letter to selected patients**



The University of Edinburgh  
12 Buccleuch Place  
Edinburgh EH8 9LN

Fax 0131 650 3891  
Telex 727442 (UNIVED G)  
Telephone 0131 650 3889

Dear ,

*RECOVERY FROM SURGICAL INTERVENTION: PATIENTS'  
ACCOUNTS*

My name is Fiona Mulgrew. I am a postgraduate research student at the University of Edinburgh. I am writing to ask you to consider taking part in a research study into women's experience of recovery from surgical operations. Participating in the study would involve you being interviewed by me on two occasions-- the first being later today for 30 to 40 minutes. The second interview would be a week or two after you have left hospital and would last about one hour. Both interviews

would be tape-recorded. The main focus of these interviews would be an exploration of what is involved, from your own experience, in getting back to health after surgery. More understanding of the patient's perspective concerning recovery will be of value to the future planning and delivery of surgical health care services.

This study will be presented in written form as a PhD. thesis and some parts of the study may also be published in health professional journals. All comments made by you, should you decide to participate, will remain strictly confidential being seen only by myself and my research supervisor. In addition, all parts of the study ( names; locations etc; ) will be changed so as to ensure the anonymity of each participant's contribution. You are under no obligation to participate in this study, and if you do, you have the right to withdraw at any time. Please indicate on the second sheet whether you are interested or not interested in participating. Place your response in the envelope provided. If you are interested I will visit you later to-day to explain the study further before you decide whether to take part or not.

Wishing you a speedy recovery,

Regards

Fiona Mulgrew

Postgraduate Research Study  
**RECOVERY FROM SURGICAL INTERVENTION: PATIENTS  
ACCOUNTS**

I am interested in participating in this study    Yes    No    (please  
circle)

Signature

Name (please print):

## *Appendix IV*

### **Hospital East: pre-admission clinic**

I visited this clinic after I had interviewed five of the patients from this hospital. The clinic was open all day on week days and on a usual day there could be about 15-20 patients to be seen. The unit was run by an enrolled nurse with a charge nurse in the main outpatients department supervising overall. On the day I visited there was another enrolled nurse and an auxillary nurse to assist. The unit was a converted ward with various sizes of rooms, single, six-bedded etc. There was a comfortable waiting room with coffee and biscuits readily available for patients and their relatives. As the morning got underway there was a good deal of coming and going from the waiting room to the various sites for separate professional contact and assessment.

The function of this unit was to assess and prepare each waiting list patient for their surgery. The clinic was set up four years previously, initially as a way of being more economical in reducing the number of days each patient was in hospital prior to surgery. It was also started to reduce the incidence of admitted patients being sent home because of insufficient beds or because they were unfit in some way for surgery so leaving a bed vacant unnecessarily. Now this pre-admission approach was being advocated and justified as a better, less stressful way to introduce the patient to the hospital and what was ahead of him/her.

The ethos of the place that was declared by the staff and by several notices on the walls, was to process patients in a multi-disciplinary way. Nurses, physiotherapists, occupational therapists, ECG technicians, phlebotomists and doctors all converged on the unit through the day. This clinic visit was arranged for about a week before the date of the operation. The prospective patient initially checked in with the clinic receptionist and was then shown to a seat in the waiting room. From there he/she was admitted by the nurse who took TPR and BP and asked questions that would otherwise have been done by an admitting nurse in the ward e.g. diet; prosthesis; bladder/bowel functioning; type of house;



next-of-kin and their health.etc,. The nurse then gave the patient an educational brochure about hip replacement and asked him/her to read it and bring it back when he/she was admitted the following week.

The patient was then assessed by the physiotherapist. This assessment mainly took the form of a functional profile in which the degree and range of movement was checked and documented for future reference. The physiotherapist mentioned briefly that she or some other physiotherapist would help them with various exercises post-operatively.

A doctor saw the patient and from my observation this consisted of a biological systems check. Before the patient's consent was sought the doctor told the patient (the session I observed was a registrar with an elderly patient needing a revision hip replacement), that there were two main risks with his surgery: dislocation and infection. He explained these risks briefly and he also talked generally about the other risks of surgery such as thrombosis, coronary etc,. although emphasising that the risk of these was minimal.

The occupational therapist's session with the patient was dominated by the need to check out what the patient's bath, chair, bed and toilet were like and then to inform him/her of the aids that he/she may be getting to help manage at home ((she was interviewing a woman who was going to have a hip replacement when I was observing)). The patient was handed a form to fill in with measurements of the domestic items already mentioned. In the moments that I had with the OT, I asked her about the ward based education classes. She told me that each patient was scheduled into one of these the day before they were to be discharged. When I asked about any literature that was given to the patients she talked about a 'precautions sheet' provided to the patient on the third day post-operatively. On this day too, according to the occupational therapist, a dressings practice was done with the patient.

A new multi-disciplinary system of note taking had been devised at Hospital East which involved all health professionals sharing the same patient case file called 'pathways'. For the pre-admission situation this had been a welcome reform as the assessment was now shared with an aim not to duplicate the information requested from

the patient. This meant for instance, that the patient was not asked his/her date of birth six times.

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